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MentalHealth

A Journey from illness to wellness

Editors

Prof. Suresh Makvana

Ankit Patel

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The International Journal of
INDIAN PSYCHOLOGY

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Forward

Several thousands of years, man considered the mind an entity within the body, an entity which has no physical form. Initially we thought that it was an independent entity, later proposed that it is a phenomenon or property of the body. Today we consider that the mind has emerged from the brain, but it is not limited by the brain. The brain learns to recognize, creates semantic and symbolic equivalents of every recognition, semantically and symbolically process, which we call thinking, articulate and orthographically represent the thoughts, and store and retrieve all that is carried out. The human brain has the privileged and interconnected centers of listening and talking brain centers, which help to create verbal awareness of the thoughts and speech one has already generated. Verbal awareness of the thoughts allows one to modify and reconstruct thoughts and their expressions until one makes meanings critically acceptable to the self. We call the semantically and symbolically processed signals in the brain information. Interestingly, the brain developed two methods of processing information based on the two types of flow of signals into the brain, which are sequential and simultaneous. The sequential arrangement of signals or information helped to understand the processing flow in the nature and universe, which became the basis of scientific understanding of all events in the time-space domains in the universe. The simultaneous processing of signals arrived in the brain from several independent resources, helped them to develop a holistic profile of events, which has been specifically useful for developing a system approach and system thinking pattern to life. The system approach helped them to define purposes and goals for life, make plans of actions and execute them in a planned manner for navigation in life. The processes related to recognition, building meanings to signals,

assemblage of meanings, their storage and retrieval became the foundation of cognitive processes within the brain. The assemblage of meaningful ideas within the brain came to be identified as a vital part of the mind.

Another equally important process present within all living beings is the emotional arousal, which serves as the driving force of life. Emotional arousal is cognitively molded in man and produce positive and negative emotions within each individual. These cognitively molded emotions have special role in life, as they decide the stability of the mental state and what we may call mental reactions to other individuals and happenings in life. The aberrations of cognitively molded emotional state contribute to what we call the mental health of the individual. Emotional arousal and the cognitive processing strategies one learns and employs have special roles in deciding the peace and health of the mind. Physical aberrations at biological levels may induce effects, which may directly facilitate such changes which may make the cognitive processing abilities inadequate, even though emotionally the individual may be partly or fully stable. On the other hand, development of cognitive processing abilities depends on the social conditioning one is exposed during the neurodevelopmental stages, and the cognitive controls the society encourages and supports. Even though emotional arousal is a nascent arousal, it acquires cognitive molds as the child grows, and individuals in general may not have the ability to hold back that cognitive framing of emotional arousal and learn to mold it with adequate controls. It has been now known than all actions have a automatic neurogenesis, and the concept of free will is meaningful only when the individual has the control on own emotional arousal, as one can learn to control the emotional arousal. Actions or responses may automatically be initiated if emotional arousal surpasses a limit within each individual. Cognitive training and retraining for the management of

emotional arousal and automatic initiations of responses and actions have become an important behaviour management technique today. It has become an imperative need that all individuals learn such controls for management of their routine behaviour, and there is need for development of need-profession specific controls, other than specialization in the area for those who study and manage behaviour and support individuals who have behavioural problems within the society.

Cognitive restructuring of thoughts and remolding of emotions have become important needs in all human behaviour management occasions, whether they are mainly for emotional management of emotionally disturbed persons or for developing goal specific personal or self-management strategies. Such emotional regulation is needed for one to excel in performance. In fact, several of the routine responses to incoming signals into the brain are made even before their recognition and awareness. Graceful acceptance of such behaviour after a response is made is possible only when one learns to produce such responses in socially accepted conditions, for e.g., for purposes of achieving excellence in performance or for avoiding self-injury or damage.

The controls used on emotional arousal and cognitive processes are difficult in several societies, because of the presence of beliefs in several more issues and forces, which influence the bidirectional to and fro journey of effects between mental health and mental illness. Human beings in general accept only experiential methods of verifications and approval of reality, when they come in contact with their own mental and physical conditions. However, many may still be influenced by suggestions and produce experiences as per suggestions, which may not respond to scientific methods of verifications and corrections. Mental health and diseases, mainly in the domain of emotional health may therefore be affected by beliefs and

psychological effects produced from cognitive processes and cognitive molding of emotions. Interventions in the cognitive and emotional domains do often work and changes may be brought out at the psychological and biological levels

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EDITORIAL

It is only when one goes through the grind that a beautiful story is born. This is the story of our special review too. Due to unforeseen circumstances it was not possible to publish the journal as per the deadlines. We are grateful to all the researchers for bearing with us and we apologize for the inadvertent and unintentional delay.

The theme “Mental Health: Journey from Illness to wellness” is self explanatory and is the bloodline of all that we do. With changing times, the perception of psychologists has shifted towards a solution oriented positive approach against the earlier problem focused approach. This led us to relook at research and one issue that we felt that needed to be looked at is the kind of research that is being undertaken currently. Research should lead to insights that bring about beneficial change in people and society. Research should feed into various streams of society leading to necessary changes that bring about understanding about issues and problems and what action can be taken to resolve those problems.

About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses. Such estimates have drawn attention to the importance of mental disorders for public health. The burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions. Because these interactions are protean, there can be no health without mental health. Many health conditions also increase the risk for mental disorder, and comorbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis.

Poor mental health is the leading or second most reason for early retirement or withdrawal from the workforce on health grounds. While these are serious impacts, they are in themselves insufficient to justify investment in measures to promote mental

health and wellbeing. For this, it is important not only to identify robust evidence-informed actions, but also to look at their costs and resource consequences, within and beyond the health system. Resources are always finite, with many potential alternative uses, and careful choices have to be made.

There has been a considerable body of research into the effectiveness of interventions to promote/protect the mental health and wellbeing. This special review is going to be the deciding parameter on which henceforth we will publish theme based special review journals. We know you will continue to support us in this endeavor so that whatever we do adds meaning and value to the world of knowledge and to the psychological society and mental health professionals.

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The Team

Prof. Suresh Makwana



Prof Suresh Makwana is Professor and Head of the department of Psychology at Sardar Patel University, Vallabh Vidhayanagar, India. He has completed his PhD from Sardar Patel University. He has received number of awards from different national and state level organizations for his contribution in the field of psychology. He also one of the founder member and editor in chief of The International Journal of Indian Psychology. He is also PhD and M.phil guide at Sardar Patel University. He has published 7 books. He is one of the pioneers of Psychology in Gujarat. He has published more than 57 research papers in different national and international journals. As such he is one of the leaders of the field he has delivered more than 23 guest lecturers for different government and non government organizations. Not only is that he also actively participating as a Life member and director and co-director of more than 20 national organizations. Indian Psychological association awarded him IPA President gold medal and he has been elected as a sectional committee member if the section of Anthropological and behavioural sciences (Including Archaeology and Psychology and Educational sciences) for 2009-2010 for Indian Science congress association.

Ankit Patel

Ankit Patel is also known as Mr. A in the field of Writing and publishing media. Ankit is 26 years one and only



boy who has published books more than his age number. He is founder of Red'Magic Networks, Inc (A unit of RED'SHINE Publication, Inc, RED'SHINE Studios, Inc, Dot'Red, Inc). Under different international publications he has published more than 25 best seller books. Ankit started creative writing when he finished his 12th Standard. His one of the first book *Mind Power* he wrote it before completing his Bachelors studies. Ankit is morally interested in creative writing in the field of psychology and he is also interested in writing in Gujarati and English literature. His one of the most top rated books are *Mind Power*, *The Secrets of Personality*, *Love Forever* and *Selected Letters of Sigmund Freud to Martha Bernays*. That book is one of the best sellers of Amazon. More than 70 thousand plus sold out books. He is also working as an editor of the International Journal of Indian Psychology and he is the one and only one of the reason behind the grand success of the IJIP. He has presented and published numbers of Research papers in the national and international journals and magazines. In 2013, Indian Psychology named him as Influential as one of the most Psychological Author in the community. He writes as op-ed Articles for English, and Gujarati publications.

Aastha Dhingra



Aastha is practitioner of one of the pioneer and eternally growing careers in the world i.e. Psychology, which gives her an opportunity to empower, support and train people for a better fulfilled and happy life. She is a trainer with some of the great educational and corporate institutions. She is an author and has almost 20 papers to her credit in various national and international journals and has received best paper awards for few

papers at national conferences. She is an anchor/speaker with NDTV Prime.

“She is driven to be the best at what she does and she wants to work somewhere where she will have opportunities to develop her skills, take on interesting projects, and work with people she can really learn from.” She has conducted various customized training programs / workshops for some of the reputed institutions. She has launched a project titled “ YOUTH EMPOWERMENT PROGRAMME: Y.E.P.” with Jesus & Merry College, DU & Enactus (NGO) for 3 months with the vision to train underprivileged children on employability skills making them capable to fetch jobs in sale and retail sector.

Vishalkumar Parmar



Vishalkumar Parmar was born in 1992 brought up in Ahmedabad, India. He received his M.Phil. in Forensic Psychology from one of its kind world's first forensic sciences university named Gujarat Forensic Sciences University in 2016. Vishal believes that humans never stops learning that's why for adding one more feather in cap right now he is doing another M.Phil in Clinical Psychology (RCI approved) from the same GFSU. Vishal is best known for his research work in the area of forensic psychology, Vishal has been trending in one of the best forensic Psychological Investigation tools For Example, Polygraph, Narco-analysis, BEOS Profiling and many more, not only that he started his journey in the field of Mental health 3 years back in 2013, He started working in one of the leading NGO's of Gujarat named Manas charitable trust for mental health. He joined Manas as a Project coordinator and senior psychologist, where he used to design new projects which can help for collaborative work

with different organizations of Govt. of Gujarat in development of mental health sector specially for specially abled children. Along with that he also worked as a visiting lecturer in couple of colleges and institutes of Gujarat University for guiding students of masters. He was just 21 years old when he stepped in the world of teaching not only that but his keen interest and work in the field of research was also appreciated by number of institutes and organizations. thus he become one of the only third Indian's to became a part of European association of Personality psychology(EAPP).He has been trained under one of the world's best experts in the field of clinical and forensic psychology he has been trained in Hospital for mental health Ahmedabad (HMH) and Directorate of forensic Science (DFS) Gandhinagar. He has designed and done number of research for the police and army officers and same he has done for Prisoners and Juveniles of the Gujarat. Vishal is specially interested in working for the betterment of mental health of criminals. According to Vishal if we want to stop crime we have to start in from parenting of child. That will be one of the best ways for stopping crime rates in India. Vishal is also working as one of the founding members of the International Journal of Indian Psychology and he is also working as one of the online editor of it. He is an author and has almost 15 papers to his credit in various national and international journals.

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Thinking NLP When Dealing with Mental Disorders Can Be a Right Choice

Aastha Dhingra^{1*}, Anshul Dhingra²

ABSTRACT

With regard to the increasing changes and sophistication of society and development of social communications, preparation of individuals, for facing difficult situations is an essential issue. With number of patients affected with mental disorders rising at an alarming rate, focus is on giving equal attention to mental health along with physical well-being for all-round excellence. The secret lies in communicating specifically with the brain verbally as well as physically through the latest psychological technique known as neuro-linguistic programming (NLP).

Neuro-linguistic Programming (NLP) developed in the USA in the 1970's has achieved widespread popularity as a method for communication and personal development. The title, coined by the founders, Bandler and Grinder (1975a), refers to purported systematic, cybernetic links between a person's internal experience (neuro), their language (linguistic) and their

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patterns of behaviour (programming). In essence NLP is a form of modelling that offers potential for systematic and detailed understanding of people's subjective experience.

It offers easy and practical approach towards curing mental disorders. It can increase the level of knowledge and have a positive effect on the various dimensions of human life. NLP not only promote individuals' general health but also to lower depression, anxiety, social function reduction, and physical problems, which will prevent mental and physical disorders.

In this paper the nature, assumptions, techniques and applications of Neuro-linguistic Programming is outlined and its potential in the field of mental health as a psychotherapeutic technique is explored and reviewed.

Keywords: *NLP, Mental Health, Mental Disorders, Therapy, Psychotherapy.*

Neuro-linguistic Programming: Background

NLP seems to us to hold much potential for education at all levels, yet it also needs research and critical evaluation. Our broad intent is to help bridge the worlds of NLP and formal education.

Neuro-Linguistic Programming (NLP) was developed at the University of California at Santa Cruz in the 1970's. Its founders and principal authors were Richard Bandler, a student of (initially) mathematics and computer science, and John Grinder, a professor of linguistics. McLendon (1989) describes the emergence of NLP between 1972 and 1981. NLP has since achieved popularity as a method for communication and personal development. It is used by professional practitioners of many kinds - managers, trainers, sales people, market researchers, counsellors, consultants, medics, lawyers and more.

NLP is an applied psychology that facilitates the analysis and reproduction of excellence in a range of clinical and non-clinical settings as demonstrated in these peer-reviewed articles (Bigley et al., 2010; Churches and West-Burnham, 2009; Gray, 2002, 2010; Gray and Liotta, 2012; Juhnke et al., 2008; Muss, 1991; Simpson and Dryden, 2011; Stipancic et al., 2010; Wake, 2008, 2011; Weaver, 2009; Witt, 2003, 2008). It is also a recognised mode of psychotherapy in the UK, accredited by the UK Council for Psychotherapy.

Thus, although NLP has come to be identified as a mode of psychotherapy in its own right, originally it was offered as a method capable of identifying the effective aspects of existing models of communication (Gestalt, TA etc.) for pragmatic purposes. Initially Bandler and Grinder were interested in figures such as Carl Rogers, Fritz Perls and Virginia Satir because of their reputation for excellence.

NLP writing and practice show influences from a wide array of fields; Gestalt therapy (Perls 1969), person-centred counselling (Rogers 1983), transformational grammar (Grinder and Elgin 1973), behavioural psychology, cybernetics (Ashby 1965), the Palo Alto school of brief therapy (Watzlawick et al 1967), Ericksonian hypnotherapy (Bandler and Grinder 1975b; Grinder et al 1977), and perhaps most importantly the cybernetic epistemology of Gregory Bateson (Bateson 1972). NLP adopts the TOTE (test-operate-test-exit) mode of functioning (Miller, Galanter and Pribram 1960). These processes depend on the dynamics of calibration and feedback (Wiener 1965, Bateson 1972).

NLP begins with a set of assumptions that operationalize a truly client-centered orientation. Most of these ideas can be traced back to Rogers (1951) and Maslow (1943) as well as Virginia Satir, Milton Erickson and Alfred Korzybski. Several of these presuppositions find a certain correspondence in the

assumptions that people generally want to be happy and to behave rationally. Among these presuppositions are:

The meaning of communication is determined by the listener's understanding. The therapist is responsible for insuring that both he and his client understand each other,

If what you are doing doesn't work, do something different. NLP assumes a level of flexibility by the therapist that allows for multiple approaches to any problem.

The map is not the territory. This tells us that neither our own nor our client's understanding of the world is an actual match for the world itself; it is our job to ensure that we have asked enough questions so that the client's and our own world-views are accurately represented in the two-way process of communication.

Every behavior has a positive intention. This means that behavior has meaning and perhaps survival value from the client's perspective; however aberrant, perverse or irrational it may be to us, understanding from the client's perspective is crucial.

Every behavior is meaningful in some context. Once we have understood the original context of the behavior, or how the client finds place for it subjectively, we have a better hope of making therapeutic progress.

There are other presuppositions but in the realm of therapeutic interventions these are the essential core.

Language and Internal Imagery

The outcome of Bandler and Grinder's initial work, NLP's 'meta-model' (Bandler and Grinder 1975a, Grinder and Bandler 1976), identifies language patterns that are believed to reflect basic cognitive processes. Mathison has, to our knowledge, been conducting the first formal testing of NLP's models of, and assumptions about, language patterns.

One of the most important beliefs within NLP is that we use all our senses to code experience internally. The technical

term for this is 'internal representation' (the word 'imagery' does not immediately juggle up the role of hearing, feeling, tasting, smelling, and movement in the coding of experience).

NLP considers that verbal reports may be literal accounts of people's inner experience. Thus when a person describes what they can 'see in their mind's eye', NLP assumes that the person is experiencing internal visual imagery (which may be outside their awareness). Furthermore the qualities and characteristics of that imagery are significant, and relate in systematic ways to other aspects of that person's experience (e.g. Feelings, beliefs, behaviour and so on).

Internal imagery appears in personal development (e.g. Glouberman 1989), psychotherapy, sports psychology and elsewhere. What NLP adds is a systematic model of distinctions within that imagery, is called 'submodalities' (Bandler 1985; Bandler and macdonald 1988), which are thought to be related to physiological responses in the body; and an approach to how such images are connected in sequences of thought processes and related behaviour (Bandler and Grinder 1979).

The idea that some forms of words can increase or decrease the amount of choice available within an internally constructed (and perhaps problematic) situation is intriguing. How people use their senses internally, and the kinds of internal representations they create, are believed to be unique to every individual. NLP does not claim that there are universal regularities in the specific content or structure of such imagery, (except that the senses are always used as an interior coding device) and so emphasizes the need to gather information about each individual's 'map of the world'. This has clear implications for the practice of teaching and learning and is in tune with a constructivist perspective.

Mental Health & NLP

In the field of psychotherapy, in the 1980s, the therapeutic use of NLP developed into Neuro-Linguistic Psychotherapy (NLPt), a unique school of psychotherapy, drawing on the principles and techniques of NLP. To avoid possible confusion, it could be said that NLPt is a specialised application of NLP in the field of psychotherapy. NLPt encompasses NLP principles and techniques, both in training and application, and has further added a theoretical basis - a model of human functioning and development and other inherent structures which are necessary for a method to be regarded as psychotherapy. While NLP has remained a somewhat eclectic field, NLPt has developed a standard curriculum for education, and a professional code of ethics based on the Code of Ethics of the European Association for Psychotherapy.

As a psychotherapy method, NLPt is based primarily on neurobiological, phenomenologically-systemic and metatheoretical considerations. It can also be defined as a systemic imaginative method of psychotherapy with an integrative cognitive approach (Schiitz et al., 2001).

A central tenet of NLPt is goal-orientated work with a person, paying particular regard to his or her representation systems, metaphors and relation matrices. Psychotherapy is regarded as a co-operative, creative process where the therapist assists the client in making desired changes in life, reaching ecologically acceptable goals. Subjective good intentions underlying symptoms of physical and/or psychological dysfunctions are acknowledged, and by that the mostly unconscious conflicts and impasses are brought to the surface for the client to examine and to look for the subjectively best way of establishing and maintaining his or her overall psychological and physical well-being (Schiitz et al., 2001, p. 25).

The Austrian school of NLPt developed a specific model of goal-oriented work introduced by Schiitz (1996) at the World

Congress for Psychotherapy in Vienna. As in most therapies, in NLPt there is a strong emphasis on the quality of relationship between therapist and client. The therapeutic process can develop well only on the basis of a solid relationship created out of mutual respect and a well-established rapport. The role of the NLPt-therapist is to accompany the client, and support him or her in defining goals, activating resources and making changes in different areas of relevance. The changes need to be in harmony with the capabilities, beliefs and values, as well as overall criteria of the client, with respect to the overall ecology of the system.

NLPt encompasses a number of techniques that can be very efficient in different stages of the therapeutic process, and also as tools the client can later use in his or her everyday life. After each therapy session, the so-called ‘future-pace’ is done with the intention of transferring the cognitive and emotional representations that were developed in the session to everyday life, thus increasing the probability of reaching the goal.

Following tools and techniques have been found to be very effective in the treatment of various disorders like depression, anxiety, phobia, PTSD etc to name a few.:

1. Time Line Therapy (James and Woodsmall, 1988; Hall and Bolstad in Linder-Pelz, 2010) – A technique based on the principles of NLP for releasing negative emotions and revisiting limiting decisions, that directs the client, in a dissociated state, to return to significant past events with “new resources so that negative emotions can be released or limiting decisions revised” (Stedman’s Medical Dictionary).
2. Drop Through – A process within Time Line Therapy that aids the release of emotions from gestalts or clusters of emotionally impactful memories.
3. Perceptual Positions – (Grinder and DeLozier, 1987) A method of viewing an experience through a number of different perspectives. The client is associated into First Position – experiencing an event through our own eyes; Second Position –

experiencing something as if we were in the other persons shoes; and Third Position – studying back and perceiving the relationship between ourselves and others from an observers perspective .

4. Parts Integration – A reframing process that recognises that we may have less integrated or less conscious aspects of ourselves that are in conflict with our more conscious self. Parts work derived from the theories of family therapist Satir (1972) and the internalized parts found in Gestalt Therapy.

5. Anchoring – The use of stimulus responses to alter states, derived from the Operant Conditioning Theory of Skinner (1957)

6. Relaxation – The use of Milton Model Language Patterns to induce a hypnotic state through visualization (Bandler and Grinder, 1975, 1977).

NLP offers possible additions to CBT that have strong validations in mainline psychology and neuroscience. The sub-modality distinctions have extensive validation in the experimental literature, while their application to therapeutic interventions is comparatively novel (Gray, Wake, Andreas, & Bolsted, 2012). The linguistic distinctions, were derived from standard linguistic categories used by Chomsky, Jacobson and others. While there is significant literature attached to their presence in linguistics, they are novel in their use in therapy.

With number of patients affected with mental disorders rising at an alarming rate, focus is on giving equal attention to mental health along with physical well-being for all-round excellence. The secret lies in communicating specifically with the brain verbally as well as physically through the latest psychological technique known as neuro-linguistic programming (NLP). NLP offers easy and practical approach towards curing mental disorders. It was founded after studying successfully methodologies of world's top therapist, anthropologist and executives. The subject implies that by changing our linguistic

pattern while communicating with our brain we can re-programme the neurological processes to improve behavioral and cognitive capabilities favorably.

NLP stood for the usefulness rather than truthfulness of the subjective thought. The NLP methodology is client-focused. The content is not important, what affects us mostly is how we organise thought in the mind. For eliminating fear, phobia, depression and negative thought, you need not access those painful experiences repeatedly, instead, we have to change the internal representation and the brain will automatically take care of the rest. This raises a pertinent query-why different influences on different people when our brain is biologically the same? The answer lies in our method of perceiving and shaping the incidents. Emotionally balanced and happy persons turn unpleasant experiences into distant, unclear and black and white images while making good ones big and coloured. On the flip side, those who are unhappy and depressed do just the opposite.

Provision of mental health is achieved by prevention and promotion of health. In this regard, realizing the need of humans, scientists tried to explore and reconstruct more humanistic methods consistent with human beings' psychological characteristics to reach their mental health. Therefore, in the recent past, some psychologists have turned to new educational and treatment methods, namely, neurolinguistic programming (NLP). This program emphasizes that human behavior originates from neurological processes. In addition, a wide spectrum of human behaviors are mediated and regulated by human language. The importance of NLP lies in the fact that this programming is a collection of skills based on psychological characteristics of the human beings through which the individuals obtain the ability to use their personal capabilities as much as possible. Research shows NLP is the science and art to reach success. Research conducted on NLP showed its positive effect on various dimensions.

It is a way of modelling exceptional and resourceful behaviours, making these transferrable to others, and of changing un-useful or pathological behaviours. NLP methodology offers a systematic approach to the observation, analysis and replication of behaviour. It provides specific assumptions about the nature of behaviour and its organisation that allow for the construction of testable models of behaviour. Like behaviourism and cognitive psychology it provides no consistent theory of personality but rather focuses on the description of behaviour from the perspective of the client's subjective experience. Between the initial observation of the behaviour and the final outcome (be that a model, procedure or technique), it produces a series of successive approximations of the behaviour under study which upon refinement yield a testable model or technique for replicating or altering that behavior (Wake et al., 2013).

An important innovation emerging from NLP's modelling is the refinement of diagnostic categories to reflect the patient's internal ordering of the perceptions that give rise to the symptom or problem. This radically client-centered approach represents a further refinement of cognitive behavioral practice. NLP recognizes the broad categorical definitions in the DSM and the ICD but captures, for clinical utilization, the almost infinite subtleties of individual experience that those categories encapsulate. NLP reimagines pathology in terms of client-specific maps, and patterns of affect and behavior that can be changed.

NLP takes the position that in the client's world, the interpretation is realistic and is experienced as threatening; her perceptions justify her responses. After all, the response has prevented the worst from happening in the past. NLP now re-codes the schema in terms of the client's perceptual distortions (known as sub-modalities) that are subject to conscious manipulation by the client. A second difference is in the use of language. Beck (Beck, 1976; Burns, 1980) and Ellis (1962) each

identified typical patterns of irrational or distorted language that describe the patient's response to the initial stimulus. These are often judgments about the content of the responses.

As a psychotherapy method, NLPt is based primarily on neurobiological, phenomenologically-systemic and metatheoretical considerations. It can also be defined as a systemic imaginative method of psychotherapy with an integrative cognitive approach (Schiitz et al., 2001).

As in most therapies, in NLPt there is a strong emphasis on the quality of relationship between therapist and client. The therapeutic process can develop well only on the basis of a solid relationship created out of mutual respect and a well-established rapport. The role of the NLPt-therapist is to accompany the client, and support him or her in defining goals, activating resources and making changes in different areas of relevance. The changes need to be in harmony with the capabilities, beliefs and values, as well as overall criteria of the client, with respect to the overall ecology of the system.

NLPt encompasses a number of techniques that can be very efficient in different stages of the therapeutic process, and also as tools the client can later use in his or her everyday life. After each therapy session, the so-called 'future-pace' is done with the intention of transferring the cognitive and emotional representations that were developed in the session to everyday life, thus increasing the probability of reaching the goal (Cameron-Bandler, Gordon, & Lebeau, 1988, based on Vaihinger).

Research on NLPt can be summarised under two perspectives: research that considers the general claims of NLPt; research that considers the effectiveness of practicing NLPt in clinical settings. Numerous studies deal with the general claims of NLP, e.g. eye movement patterns (Bliemeister, 1987; Dooley & Farmer, 1988; Wertheim & Habib, 1986), representational systems (Mattar, 1980; Schiermann & Ringelband, 1985), or

further basic aspects (Konefal, Duncan, & Reese, 1990; Einspruch & Forman, 1988; Reckert, 1994; Weerth, 1992), and while some of those studies could to a greater extent confirm the hypotheses on validity of NLP concepts, other studies did not find evidence for the basic assumptions.

In a review of the experiential literature Sharpley drew the conclusion that the effectiveness of NLP therapy was yet to be demonstrated. In their comment on that review, Einspruch and Forman made an evaluation of design and methodological errors in empiric studies of NLP, also offering suggestions for improving the quality of research on NLP. Sharpley (1987) added further data from seven research studies demonstrating that the research data do not support either the basic tenets of NLP or their application in counselling situations, once again repeating the dilemma whether the lack of evidence for NLP claims and effects reflects the faulty premises of NLP or the methodological shortcomings of the studies.

Until now only a few publications dealing with the effectiveness of NLPt in real-life counseling or psychotherapeutic contexts can be found. Genser- Medlitsch and Schiitz (1997) compared 55 clients of NLPt and 60 wait-list controls by questionnaires concerning individual complaints, clinical symptoms, coping strategies and locus of control. Ratings of clients and therapists concerning the perceived success of treatment were also included. Improvements in the therapy group were significantly superior to those in the control group, and most of the therapy effects remained stable in the six-month follow-up. NLPt effectiveness was significantly influenced by the treatments' duration and by the clients' age and gender.

A study of the effectiveness of NLPt by Huflejt- Lukasik (in preparation) examined the effects of neuro-linguistic psychotherapy on self-focused attention of the patients. Indicators of the effectiveness of the psychotherapy were:

decreasing psychopathological symptoms and better strategies of dealing with stress. The level of self-focused attention was measured as an indicator of adaptive self-regulation, as high, long-term self-focused attention is considered a sign of difficulties in self-regulation. The results indicate that NLPt is an effective method in reaching positive change. During therapy there was a permanent decrease in patients' psychopathological symptoms and emotion-orientation in dealing with stress. The level of self-focused attention also decreased.

The 'study of effects of mental allergy therapy' within the Hildesheimer Health Training®, which is based on NLPt, was conducted by Witt (1999) and showed that NLPt can modulate the skin reaction to histamine in pollen-allergic humans and improve their state of health. In this study, the goal was to examine the effects of NLPt in private psychotherapeutic practice. Most of the participants were seeking psychotherapy, either because they wanted to reduce clinical symptoms or because they desired to achieve a higher quality of life (i.e. be happier or more successful, etc.). Thus, clinical symptoms and quality of life seemed to be the most appropriate targets for NLPt evaluation.

When we talk about social phobia, a distorted framing of perspective has been recognized as a hallmark of social phobia (Alden & Wallace, 1995). A phobia is an externally triggered, consistent, uncontrollable panic response to an internal representation. You actually respond to the picture you have created, not the thing. The thing triggers, it does not cause. This is a major point. What makes a phobia different from a single painful experience? The fear has become connected with a set of signals or cues. That is a snake or a hose can trigger the panic response for instance. A phobic response is very different from intense fear. A phobic reaction is traumatic, debilitating, immobilizing and seems completely out of a person's control. Cognitive restructuring (Mattick, Peters, & Clarke, 1989),

reframing (Aklllas & Efran, 1995), and rational roleplaying using positive, counterbalancing self-messages (Marks, 1995) are some of the techniques used to address social phobia. Parallel concepts and methods have been employed in Neurolinguistic Programming and used in this treatment of phobias (Rosa, 1988; Einspruch & Forman, 1985; Sterman, 1991; Barnett, 1990) and in a research setting (Einspruch & Forman, 1988). Research (Konefal, Duncan, & Reese, 1992) indicated significant psychosocial changes can follow, including a reduction in scores on trait anxiety, even among a control group who achieved the expected "normal" scores on anxiety in pretraining evaluations. In a study (Duncan, Konefal, & Spechler, 1990), it was shown that those in neurolinguistic training also increased scores on self-regard, self-acceptance, and the capacity for intimate contact with others.

Although a specific phobia can take years to cure by conventional methods, the NLP phobia treatment, which involves dissociation, can cure phobias in one session. A key characteristic holding a phobia together is that it is a very associated state. Post-traumatic stress disorder has the same structure. The key component in the NLP phobia treatment is the dissociation. We need to disconnect from the emotions. You can use this technique for strong unwanted emotional states or responses that are not necessarily phobias. That is anytime it would be more useful to have a more neutral response.

Numerous follow-up studies have tracked patients after leaving treatment for periods ranging from six months to over five years. These studies are fairly consistent in demonstrating that treatment effects are enduring. For example, the study of NLPt by Genser-Medlitsch and Schutz (1997), reviews of depression (Nicholson & Berman, 1983; Neimeyer, Robinson, Berman, & Haykal, 1989), social phobia (Feske & Chambless, 1995), generalised anxiety disorder (Gould, Buchminster, Pollack, Otto, & Yap, 1997).

In the case of depression, the focus is on past experiences - failures, losses and defeats which have already happened and are thus fixed facts. The depressed person may not even have a future time line to be anxious about, let alone to have goals in. Their comments about life and their own self are thus based on a "permanent pervasive style" of explanation ("This is the way I and other things are; everything is like this, and it always will be"). The depressed person has understandably little interest in doing anything, because they expect failure ("What's the point, it only gets you to the same place I've always been - nowhere."). They may get hopeful about specific tasks (and then use the patterns we are calling anxiety), but generally the depressed person has given up trying to avoid the kind of pain that the anxious person is running from. NLP practitioners may use three different techniques to rewire the client's thinking process from a negative to a more positive state of mind.

The techniques include:

- Anchoring, which refers to the refers to the transference of the client's positive response from one group of events/circumstances to another
- Reframing, a technique also employed by other forms of psychotherapy. Reframing functions to give an additional set of references or new perspectives from which the patient can view his or her world.
- The use of metaphor

Using these techniques, a professional NLP practitioner will help an individual modify the way in which they presently manage their own thought processes and behaviors. This modification in turn helps eliminate any unwanted negative outcomes currently being experienced in their life situation.

In the anxious person, the focus is on potential future defeats, failures and losses. The anxious person considers these disasters as being possibly avoidable, if they can only escape in some way from certain feared events. Their style of explanation

is thus more tentative, conditional and more focused on particular events ("If I can only avoid elevators / crowds / thinking about death, then I might be able to escape this terror."). The anxious person has objectives, then, but is unable to reach them. They fear failure. The anxious person does not give up on doing everything (unless they finally got depressed about their anxiety) but gives up on doing the things they fear (the triggers for their anxiety).

The following five sets of NLP tools are intended to be used inside this context, to reverse the "cognitive distortions" of anxiety. The tools are: Reframe Anxiety and its Symptoms; Access Resources/Solutions; Teach Trance and Set Relaxation Anchors; Alter the Sub modalities; Create More Integrated Beliefs.

NLP advocates points out that most people quit their addiction without any help from groups like Alcoholics Anonymous. It is claimed that the reason they were able to do this was because their thinking had changed. Therefore, proponents of NLP argue that the best way to treat an addiction is to change the way the people think. This can be done through motivational interviewing. The aim is not to try to scare people into quitting their addiction, but in teaching them how to develop the motivation to quit. This type of therapy can be provided by an NLP practitioner in a one-to-one session

CONCLUSION

Thus, to summarize, in NLP, clinical work finds the specific internal representations that produce the emotional or cognitive response that gives rise to the problem. Hence, a depressed client may be obsessively repeating the pictures of his mother's recent death and producing the symptoms of diagnostic generalization, depression. The NLP formulation must always contain the internal steps or process by which the client 'does the problem'. NLP therapeutic operations are validated when

changes in the internal sequences of the internal representations constituting the problem result in problem resolution. NLP describes the target behaviour, identifies its structure, and the possible modifications that are indicated for problem resolution. NLP has proceeded as an intuitive, empirical art. NLP provides a set of tools that hold forth the promise of increasing the personal specificity and effectiveness of CBT. Finally, a wealth of NLP techniques for changing beliefs can be used to alter the irrational beliefs once they have been accessed (notice that while they are kept separate in the panic part of the person, the person does not experience them as real and does not "need" to change them). Some level of integration needs to occur for belief changes to access the part of the neurology generating the problem belief.

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Yoga and Mental Health: An Underexplored Relationship

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ABSTRACT

Yoga is a way of life comprising mental, physical and spiritual attributes to achieve holism, meaningfulness, excellence and completeness in all walks of human functioning. It entails energizing and fuelling processes which lead an individual to make a balance in his/her personality and incite him/her to achieve greatest social, psychological, spiritual and moral coordination juxtaposed with most creative and productive functioning at individual, family, community, societal, national, international and cosmic levels. The present paper attempts to explicate and assess the role of yoga and yogic practices in achieving, preserving and promoting mental health. The curative, preventive and promotive role of yoga and yogic practices in mental health and human functioning have been discussed and substantiated. The major psychotherapeutic practices and techniques based on yoga and yogic practices have been discussed in length. In addition, the mechanisms through which the yoga and yogic practices exert their influences on mental health and human functioning have also been given sufficient

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place based on scientific findings of psychological science. The conclusions of this endeavor demonstrate that the real value and place of the yoga and yogic practices have to be conveyed to the people of the world. The time has come to make aware the world about its real meaning and value and also use this platform to decipher the traditional Indian knowledge before the world civilizations to mitigate all sorts of problems facing humanity of the world today. The depth and vitality of the yoga and yogic practices and the multiple value of this interdisciplinary branch of knowledge is underexplored as per the scientific standards. It necessitates eclectic global efforts to situate this priceless Indian traditional knowledge at the place where it ought to be. The conclusions of this paper would be of great value for the academicians, policy makers, administrators, students, and the public at large. Owing to its significance in all aspects human development and functioning of the whole world, The United Nations has rightly declared June 21 of each year as International Yoga Day since last year. This is really a recognition and honour to the great Indian civilizations and its people.

Keywords: *Yoga, Mental Health. Psychotherapy, Human development*

The Indian tradition, culture and civilization have long historical background and diversified schools of thoughts characterized by logical coherence, emphasis on spirituality, meaningfulness and wholeness encompassing material, social, cultural, spiritual and religious aspects of human existence and functioning juxtaposed with deep philosophical foundations. It encompasses almost all aspects of life with sufficient and acceptable evidences with suitable arguments culminating India and Indian civilization as leader of the world. Many traditions, knowledge, concepts and ways of life of Indian society have

been acceptably transported to other civilizations of the world with great reverence and admiration. The yoga and yogic practices are among one of the most popular contribution which has galvanized the whole world. Owing to the efficacy and usefulness of yoga and yogic practices for the people irrespective of socio-cultural differences, the United Nations (UNO) has declared June 21 of each year as International Yoga Day which evinces a recognition and honour to the great Indian civilizations and its people.

The Yoga and yogic practices are relevant and effective today not only to treat physical and mental disorders of various sorts but also to maintain, preserve and promote a healthy, happy and successful life. This is even more useful in the wake of increasing physical and mental health problems as a consequence of adopting and practicing of material values, stiff competition, restructuring of family, social and community relations and information overload caused by recent advances in computer technology and mass media.

Yoga is a way of life comprising mental, physical and spiritual attributes to achieve holism, meaningfulness, excellence and completeness in all walks of human functioning. It entails energizing and fuelling processes which lead an individual to make a balance in his/her personality and incite him/her to achieve greatest social, psychological, spiritual and moral coordination juxtaposed with most creative and productive functioning at individual, family, community, societal, national, international and cosmic levels. It has proven itself in achieving, preserving and promoting mental health. Its curative, preventive and promotive roles in mental health and human functioning have been well understood. There are many psychotherapeutic practices and techniques which are based on philosophical principles of yoga. There are four branches of yoga: Karma Yoga- action, Bhakti Yoga- devotion, Jnana Yoga- Self-study and Raja Yoga- will-power. The Raja Yoga proposes eight-limbed path with their

psychological correlates. They are: Yamas -Behavior-interactions, Niyamas-Behavior-individual, Asana-Posture, Pranayama-Breathing, Pratyahara-Withdrawal of senses, Dharana-Concentration, Dhyana-Effortless now and Samadhi-Complete absorption. These are so intertwined and inter-related that without one the other is irrelevant and ineffective.

People suffering with mental health problems such as depression, anxiety and stress frequently go for self-help treatments before seeking treatment from a medical or mental health professional (Oliphant, 2009) to maximize financial savings, to refrain from consuming synthetic medications, or avoid negative stigmatization as well as in pursuance of their desire for more holistic treatment. These come under complementary alternative medicine which are applied to treat many sorts of mental and physical illnesses (Barnes, Bloom, & Nahin, 2008; Faass, 2006). It refers to a group of diverse medical and health care systems, practices and products that are not generally considered part of conventional medicine (National Center for Complementary and Alternative Medicine (NCCAM), 2010). Yoga and yogic practices come under the mind-body interventions category which emphasizes the interactions among the brain, mind, body and behavior with the intent to use the mind to affect physical functioning and promote health (NCCAM, 2010). These practices based on Yoga are employed to treat various mental health disorders, including anxiety and depression (Gerborg & Brown, 2007). It has been argued that yoga based therapies are effective and used a set of psychotherapy but the mechanisms involved in the healing process are not understood (Douglass, 2009).

It has been demonstrated that the real value and place of the yoga and yogic practices have to be conveyed to the people of the world to make it popular and useful. The current experiences of humanity make it evident that the time has come to make aware the world about its real meaning and value of

yoga and yogic practices to translate the traditional Indian knowledge before the world civilizations having capability to alleviate all sorts of problems facing humanity of the world today. The depth and vitality of the yoga and yogic practices and the multiple value of this interdisciplinary branch of knowledge is underexplored according to the scientific standards. The mental health professionals may benefit from learning what makes yoga effective and why and how to incorporate their learning into their practice with clients. By understanding the relationship between yoga and physiological functioning, mental health professionals may appreciate the benefits of yoga consequent upon which they can offer a more comprehensive and useful therapeutic treatment.

YOGA AND MENTAL HEALTH

According to World Health Organization (WHO, 2014), mental health is not just the absence of mental illness. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. According to Indian Philosophy, Yogas is '*Chitta Vritti Nirodhah*'-A technique to quiet the mind or the restraint of the modification of the mind-stuff is yoga (Patanjali, 1978/1999). There are many benefits of Yoga. They can be classified as physical benefits, mental benefits and spiritual benefits. The physical Benefits of Yoga are to create a toned, flexible, and strong body, to improve posture, to improve energy level, to help maintain a balanced metabolism, to enhance functioning of respiratory, digestive, endocrine, reproductive and elimination systems, to reduce blood pressure, to improve efficiency of lungs, to enhance sleep, to promote cardiovascular and circulatory health, to relieve pain, to improve athletic performance and to improves balance. The major psychological

benefits of Yoga are to calm the mind, to attune people to the environment, to enhance concentration and mental clarity, to reduce stress and anxiety, to encourage positive thoughts and self-acceptance and to promote flexibility followed by the spiritual benefits in which the awakening the spirit, building of healthy spiritual awareness, promotion of interdependence between mind, body, and spirit, enhancing the concept of oneness of all things and connecting personal energy to divine energy are incorporated.

THE MECHANISMS OF RELATIONSHIP

The yoga and yogic practices are comprehensive in nature which involves psychological, biological and spiritual mechanisms and characterized by a new and promising approach with no negative side effects and proven scientific and practical implications covering all people. The researchers have argued that Yogic practices induce brain changes resulting in greater activation in left than right prefrontal cortex (Davidson et al., 2003). Some studies have demonstrated that yoga based exercises are responsible for formation of new neural pathways (Kreiman, Koch, & Fried, 2000). In their study, Lazar et al. (2005) and Lazar (2006) have found that yogic practices affect resonance circuitry which increases thickness in medial prefrontal cortex and insula, especially right side resulting in empathy, interoception and attunement to self and others, logical and intuitive processing (Kreiman, Koch & Fried, 2000). These practices also lead to decreased vulnerability to stress in healthy exercising adults (Baldwin, 1999). In their study on 113 psychiatric patients, Lavey et al. (2005) have found that yogic practices help regulate mood. In another study, these practices have been found to benefit emotionally distressed women (Michaelson et al., 2005).

The Yoga and yogic practices have also been found to benefit the patients with cardiovascular disease associated with

insulin resistance in diabetes (Innes et al., 2005), sleep (Cohen et al., 2004, Khalsa, 2004), back pain (Sherman et al., 2005, Williams et al., 2005), migraines (John et al., 2007). In a clinical sample, these practices were associated with alleviating the problems of depression and anxiety by increasing GABA levels (Streeter et al., 2007) and facilitated the individuals in stress response by affecting Amygdala (Reivich et al., 2002). Yoga and yogic practices have also been reported to affect the functioning of Hypothalamus and stress response which are responsible for regulating blood pressure, blood sugar, heart rate, respiration. By having an impact on relaxation response, yogic practices have an influence on anterior cingulate cortex and hippocampus which facilitate good decision-making, empathy, emotion, memory. It has been reported that yoga and yogic practices induce physical strength, increased flexibility and reduced physical tension (Khalsa et al., 2009). In another study, these practices have been shown beneficial emotional, psychological, behavioral, and biological effects (Shapiro et al., 2005) and significantly increased feeling of well-being (Dey et al., 2003). Yoga also produces change in the neurophysiology of the body (Douglass, 2009).

There is a strong consensus that Yoga and yogic practices have positive impacts on the human functioning and performance. The mechanisms through which these practices exert their influence are many. It is postulated that yoga is effective because it positively alters brain neurochemistry (Streeter et al., 2007). It “counteract[s] stress and reduce[s] autonomic arousal” (Khalsa, 2004) of the autonomic nervous system (ANS) including the sympathetic nervous system (Ross & Thomas, 2010). Researchers examining the breath work have reported that regular practicing of Yoga increases heart rate variability (Khattab, Khattab, Ortak, Richardt, & Bonnemeier, 2007), decreases blood pressure levels (Harinath et al., 2004) and decreases respiratory rates (Raghuraj & Telles, 2008). It also

helps the sympathetic and the parasympathetic nervous systems to function effectively in response to stress instead of becoming hypo-reactive or hyper-reactive (Brown & Gerbarg, 2005).

There is another hypothesis which argues that yogic practices have regulatory effects on the release of various neurotransmitters. Melatonin is believed to regulate mood and sleep patterns (Douglass, 2009). In a study of Harinath et al. (2004), researchers found that participants showed increased melatonin levels after practicing yoga. Serotonin is also believed to improve mood states (Douglass, 2009). In another study of Davies et al. (2006), it was reported that serotonin regulates both psychological and cardiovascular responses to stress in people with anxiety. Lower GABA levels have been found in people with depression (Brambilla, Perez, Barale, Schettini, & Soares, 2003) and anxiety (Lydiard, 2003). Streeter et al. (2007) speculated that the physical postures of yoga increases GABA activity levels in the brain, thus decreasing anxiety and depressive symptoms.

The researchers have also proposed some psychological mechanisms through which yoga and yogic practices exert their influence on human wellness. The self-perception theory or facial feedback hypothesis (Laird, 1974; Schnall & Laird, 2003) argues that voluntary changes in facial expression and motor behaviours also result in consonant psychological changes. The yoga based therapies lead to increased self-awareness, positive self-image, self-confidence, concentration, potentiality, productivity, social skills and relationships, emotional competency, resilience, sleep regularity and spirituality. It helps in de-conditioning and re-patterning of human behaviours. It increases acceptance and helps in re-patterning of behaviours. For example, Kriya Yoga is an intense effort which is directed by the discriminative faculty, intellect and helps to orient towards clear seeing and emphasizes present moment awareness and self

study. It enhances acceptance and help reducing behavior that is harmful to self and others.

The yoga and yogic practices enhance the ability to override habitual tendencies resulting into increased freedom in any given situation. The effectiveness of Yoga and yogic practices relies on the way they are incorporated and practiced by the individuals. These are practiced both at body and mind levels and enhance mindfulness and peace of mind. Yoga is a good source for Positive Psychology which advocates for positive interventions to broaden the views and build the capabilities inherent in all human beings. It will create atmosphere to provide context for de-contextualized practice.

CONCLUSIONS AND FUTURE DIRECTIONS OF RESEARCH

Many concepts have been proposed by the psychologists. Aristotle (1985) had talked about- eudaimonia whereas being cognition vs. deficit-motivated cognition have been focused by Maslow (1968/1999). The healthy-mindedness (James, 1892, 1897), learned optimism and optimistic explanatory style (Seligman, 2002), human flow (Csikszentimihalyi, 1997) and Broaden and Build theory (Frederickson, 1998) are some of the constructs in psychology similar to ones proposed by the philosophers of yoga. Thus, Yoga is a practice of recognizing and re-educating habitual patterns of thinking by cultivating wholesome thoughts. It may help regain balance, flexibility, strength, focus, relaxation, awareness of patterns, where stuck, start to become un-stuck and conviction with experience. These discussions make it evident that the yoga and yogic practices have sufficient capacity to help maintain, improve, cultivate and nurture health and happiness in the lives of individuals, societies and communities. It is also evident that Yoga as a psychotherapeutic technique has been applied to only a limited number of mental disorders such as Schizophrenia, anxiety and

depression (Khalsa, 2013). The mechanisms through which yoga plays a role in the treatment of different mental disorders is yet to be known and established, although its effectiveness is doubtless. Yoga practices can have a place in the healthcare system as a treatment for a variety of psychiatric conditions, at least as an adjunctive if not as a primary therapy (Khalsa, 2013). It will be logical to conclude that the relationship of mental health and yoga has been underexplored and the future research must take these issues in more rigorous and scientific manner. These conclusions would be of great value for the academicians, policy makers, administrators, students and the public at large. It carries great significance for all aspects of human development, functioning and performance.

Conflict of Interest

The author has no conflict of interest with anyone.

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Positive Body Image and General Health: A Mixed Methods Study

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ABSTRACT

The present study aimed to explicate the impacts exerted by positive body image on the general health including mental health of the participants. Sixty seven male and female students with age ranging from 20 years to 30 years pursuing their undergraduate and postgraduate programmes participated in the present study. The study was conducted in two phases using explanatory research design, a form of the mixed methods design. It uses quantitative study followed by qualitative study. In the first phase of the study, the positive body image and general health were measured by two distinct standardized psychological tools. The results of the study indicated that the female participants amassed higher mean score on Body Appreciation Scale as compared to their male counterparts. The participants also showed higher mean score on general health as compared to the male participants. The scores of the positive

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body image of the participants were positively correlated to the scores of their general health. In addition, the scores of the positive body image of the participants predicted their general health. In the second phase of the study, eight extreme scorers on Body Appreciation Scale were chosen for qualitative study involving semi-structured interview to find out the basic themes regarding the nature and significant correlates of positive body image. The thematic analysis of the qualitative data demonstrated that the low and high scorers on positive body image differed in their meaning and determinants for the positive body image. The results of the study have significant theoretical and practical implications for eating disorders, body dissatisfaction, general health and well-being. It will be equally important for psychotherapeutic and counseling purposes. The findings of the study would have noteworthy theoretical and practical contributions for the researchers, clinicians, government health policy makers, health professionals and administrators. It will equally attract the attention of the researchers of interdisciplinary disciplines. The results have been discussed in the context of current theories of positive body image and general health. The future directions for the researchers have also been given.

Keywords: *Positive Body Image, General Health, Eating Disorder, Self-Esteem, Well-being.*

The recent years have witnessed an upsurge in the scientific study of body image due to growing conviction about its implications in various aspects of human functioning and performance including mental and physical health. In the recent past, it has been reported that positive and negative body images of the individuals are strongly associated with different health, social and psychological outcomes such as eating disorder,

unhealthy weight control behaviors, health habits, risky sexual practices, social relationships and self-esteem (Jain & Tiwari, 2016; Tiwari & Kumar, 2015; Tiwari, 2014; Tiwari, 2015). It has been significantly associated with mental and physical health and life satisfaction (Jain & Tiwari, 2016; Tiwari & Kumar, 2015). Health is the level of functional or metabolic efficiency and essential for productivity and performance for the individuals or communities to adapt and self-manage in the face of physical, mental or social challenges. Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1948). The major components of body image influencing the human functioning include desire to lose weight; look beautiful, healthy and energetic with productive and good performance. The body dissatisfaction or negative body image has been reported to play important role in the development of obesity, depression and psychological disturbances of various sorts. The relationship among obesity, psychosocial factors and depression was examined in a study of 2294 adolescents which indicated that adiposity accounted for 62% of the total effect of depressive symptoms through its association with pressure to be thin and body dissatisfaction in boys and girls (Chaiton et al., 2009).

Studies show that the Hispanics were found more depressed and had lower self-esteem than other racial-ethnic groups, a difference that remained after controlling the effect of body image. It was observed that African-Americans had positive body image. The impact of perceived pubertal timing on body image varied considerably with gender and racial-ethnic groups. Thus, it can be concluded that negative feelings about their bodies contributed to the higher prevalence of depressive symptoms and lower self-esteem among girls (Seigal, Yancey, Aneshensel, & Schuler, 1999). It was observed that women are less satisfied with their body and for many types of treatment or alteration and exhibited difficulty in taking decisions. It was

found that body image is an important factor in taking treatment decisions for women. It was also argued that the women who received breast conservation had better body image two years after treatment than women who had mastectomies (treatment for removal of whole breasts) whereas the women who preferred breast conservation but received mastectomy had the poorest body image. Body image is important for the women of all age groups taking the treatment consistent with preferences about appearance associated with important long-term mental health outcomes (Figueiredo, Cullen, Hwang, Rowland & Mandelblatt, 2004). The research reported that personal connection with obesity, experience of childhood obesity or overweight parent were significantly associated with a greater perception of disease risks. These conclusions were consistent with the findings of the previous studies which have shown that self-protective health practices tended to vary with personal experience with an undesirable life event (Gross, Gary, Browne & LaVeist, 2005)

Body image is closely associated with a number of unhealthy behaviors. For example, body image can affect the possibility that an individual will engage in, or avoid, exercise (Choi, 2000; Grogan, Evans, Wright, & Hunter 2004). Being dissatisfied with the way people look and feel fat of themselves can in some cases motivate them to involve in exercise (Grogan et al., 2004). Body dissatisfaction and size underestimation in men may also lead to use of anabolic steroids and other drugs to increase muscularity (Wright, Grogan, & Hunter, 2000) which increase the risks of blood-borne diseases liver, kidney and other health problems (Pope et al., 2000). Eating behaviors are important factors affecting the body image of the individuals that may influence whether they eat healthily or restrain our eating (Cooley & Toray, 2001; Stice, Presnell & Spangler, 2002). Body dissatisfaction and excessive investment in the body have been shown to be associated with unhealthy eating behaviors, including binge eating, restrictive dieting and self-induced

vomiting (Levine & Piran, 2004). Body dissatisfaction and excessive body concerns can affect the decision of the individuals to quit smoking (King, Matacin, White, & Marcus, 2005). Body concerns and dissatisfaction can also lead to undertake unnecessary cosmetic surgery leading to health risks (Davis, 1995). Thus, it can be concluded that body dissatisfaction and body concerns are allied with many key health behaviors (Grogan, 2006). The review of the literature demonstrated that negative feelings about body contribute to the higher prevalence of depressive symptoms and lower self-esteem. Negative feelings about their bodies contribute to the higher prevalence of depressive symptoms and lower self-esteem among girls (Seigal, Yancey, Aneshensel, & Schuler, 1999). It can be argued that body dissatisfaction and body concern are allied with many key health behaviors (Grogan, 2006). Many physical health conditions have also been associated with body image dissatisfaction and lowered life satisfaction (Mudgal & Tiwari, 2015). The higher levels of psychological distress such as anxiety, depression and lowered self-esteem have been reported by people living in skin disease conditions (Tiwari, 2014). The individuals suffering with chronic disease like Cancer, HIV/AIDS etc. undergo and face many undesirable physical and psychological changes which affect the nature and level of their body image satisfaction which, in turn, determine the quality of life (Jain & Tiwari, 2016). The review clearly evinces that there is a dearth of studies showing the impacts of positive body image on general health of the individuals. This is the case with both Indian as well as Western and American societies. In addition, most of the previous studies have been conducted applying quantitative methods which lack sufficient insight and implications. The present study attempted to explore the nature and extent of the impacts of positive body image and gender on the general health of the participants. In addition, it also aimed to find out the major themes and mechanisms of

positive body image which might be involved in shaping the general health of the participants using Mixed Methods Design which comprised both quantitative and qualitative methods of data collection and analyses.

Objectives

The present study was carried out with the following objectives to study the relationship of positive body image and general health:

1. To assess the impacts of positive body image on the general health of the participants,
2. To study the gender differences in positive body image on the general health of the participants,
3. To find out the major themes of positive body image of low and high scorers on Positive body image
4. To develop an understanding of the mechanisms through which positive body image shapes general health of the participants.
- 5.

Hypotheses

The following hypotheses have been framed for the quantitative part of the study:

1. The female participants will show higher mean positive body image score as compared to the male participants.
2. The positive body image of the participants will be positively correlated with their general health.

METHODS AND PROCEDURE

Sample: Sixty seven male and female participants were recruited as the sample for the study. Out of this, 30 were males and 37 were females. All the participants were regular students of the different department of Doctor Harisingh Gour University, Sagar, Madhya Pradesh, India. Their age ranged from 20 years to 30 years. Most of them belonged to urban middle class Hindu

families with different socioeconomic backgrounds predominantly lower middle class.

Tools: *The following tools were employed in the two phases of the study to collect and analyze the data of the study:*

a. Phase I: First part of the present study was quantitative in nature. To assess the degree to which participants had positive image towards their bodies, the Body Appreciation Scale (Tylka, 2006) was used. The scale was originally in English which was translated first in Hindi followed by retranslation in English. The scale consists of 13 items measuring the feelings, perceptions, and decisions of the body image of the participants which were rated on a 5-point scale (1 = Never, 5 = Always. The higher scores reflected greater body appreciation whereas lower scores showed lower body appreciation.

The General health of the participants was measured by the General Health Questionnaire (Goldberg & Hillier, 1979). The participants were asked to compare their recent psychological state with their usual state. For each item, four alternatives 1, 2, 3 and 4 available denoting not at all, no more than usual, rather more than usual and much more than usual, respectively. The total scale score ranged from 28 to 112. The higher the score the poorer it indicated the physical and psychological health of the participants.

b. Phase II: Second part of the study was qualitative in nature in which semi-structured interviews were conducted that was audio-taped with the help of audiotape recorder. Its verbatim inscriptions were prepared to find out the major themes for positive body image using Thematic Analysis Method. The interview protocol was prepared after an in depth study of nine research articles on positive body image (Bailey, Gammage, Ingen & Ditor, 2015; Frisen & Holmqvist, 2010; Halliwell, 2015; Swami, Cass, Waseem & Furham, 2015; Swami, Hadji-Michael & Furnham, 2008; Tylka & Wood-Barcalow, 2015; Tylka &

Wood-Barcalow, 2015; Tylka, 2012; Webb, Wood-Barcalow & Tylka, 2015; Wood-Barcalow, Tylka & Augustus-Horvatah, 2010). The researchers read these articles thoroughly and prepared a list of major attributes of positive body image. Then, this list of attributes was distributed among three researchers with the request to categorize the contents or the attributes in major categories followed by a conference to develop a consensus about the major attributes of positive body image. After the consensus was reached; the researchers prepared a list of items for semi-structured interview. Following are the items which were finally included in the interview protocol of the study:

1. What type of image you have in your mind about your body?
2. Do you respect and appreciate your body in spite of differences in your ideal and real body images?
3. Do you see beauty; feel comfort, confident and happiness from your body which is often expressed in your demeanor?
4. In what type of activities do you engage yourself to maintain positive body image?
5. Do male and female differ in their positive body image?
6. How do socioeconomic status and heredity affect positive body image?
7. How do media and society encourage/promote people to make their body image positive?
8. How do you perceive thin ideal body image portrayed by media?
9. Do you want to alter or modify shape of your body?

Procedure

After having been debriefed about the basic goals of the study, the participants submitted their written consent to take part in the study. It was made clear that their participation in the study was voluntary and they could withdraw themselves from the study at any point of time. The participants were made comfortable and the researchers established rapport with them

followed by oral instructions about the methods of answering to the alternatives of the items of the scales. Then the participants were given a set of the two scales. Each item of the Body Appreciation Scale carried numbers 1, 2, 3, 4, and 5 on the right margin which signified Never, Seldom, Sometimes, Often and Always, respectively. The participants had to put the Circle (0) on the number denoting their closest meaning/feeling for the contents of each item. The mean, standard deviation (SD), t-test, Pearson Product Moment method of Correlation and regression analyses were carried out on the collected data of the study.

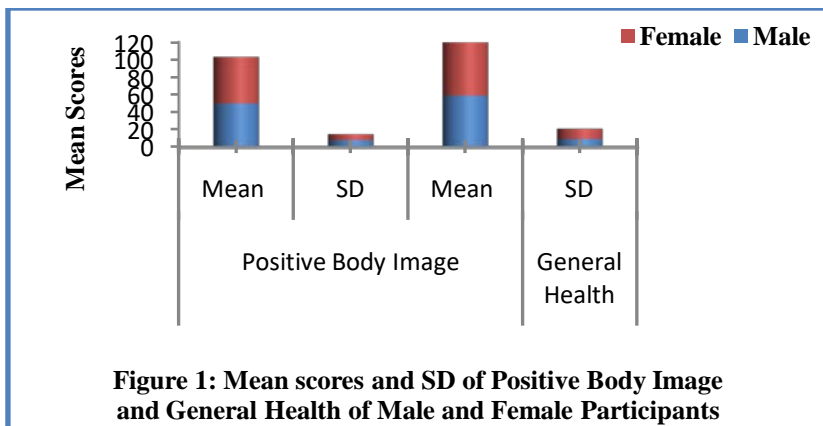
RESULTS

PHASE I

The results of the study demonstrated that female participants ($M = 53.03$, $SD = 7.07$) showed higher mean score on positive body image as compared to their male counterparts ($M = 50.00$, $SD = 8.27$) which was statistically significant ($t = 2.10$, $p = .05$).

S. No.	Gender	Positive Body Image		t	p	General Health		t	p	N
		Mean	SD			Mean	SD			
1.	Male	50.00	8.27	2.10	.05	59.00	9.60	.529	.603	30
2.	Female	53.03	7.07			60.87	12.07			

Likewise the female participants again emitted higher mean score ($M = 60.87$, $SD = 12.07$) as compared to the male participants ($M = 59.00$, $SD = 9.06$) on the measure of general health. The mean score was not statistically significant ($t = .529$, $p = .603$). The same have been displayed in Figure 1.



The scores of positive body image and general health were treated with Pearson Product moment method of correlation which showed that positive body scores of male ($r = -.241, p = .199$) and female ($r = -.201, p = .233$) participants were negatively correlated with their scores of general health. When the data of males and females were pooled the coefficient of correlation was also negative between the scores of positive body image and general health of the participants ($r = -.193, p = .118$).

The values of regression analyses showed that 5.8% of the variance in the scores of general of the male participants was predicted by their positive body image ($F = 1.73, df = 1, 28, p = .199$) whereas 4% of the variance was accounted for in the scores of general health of the female participants by their scores of positive body image ($F = 1.47, df = 1, 28, p = .233$). These results have important implications for research and practice. The data of general health and positive body image were pooled which evinced that 3.7% of the variance in general health of the female participants was contributed by their positive body image scores ($F = 2.51, df = 1, 65, p = .118$).

Phase II

Eight participants with equal number of male and female extreme scorers on Body Appreciation Scale (Tylka, 2006) were

chosen for the semi-structured interview according to pre-developed plan. The data were audiotape recorded and verbatim inscriptions were prepared and given to three researchers (including these two researchers) to sort out the major themes inherent in the inscriptions. The researchers independently gone through the inscriptions and came to their independent themes. Then, the themes so gathered were discussed in a conference of these three researchers to arrive at a consensus. After the thematic analysis, the major themes of the positive body image were emerged.

Low and high scorers on Body Appreciation Scale slightly differed in their conceptions of positive body image. The low scorer male and female participants expressed some minor concerns about the attributes of their body and showed some body dissatisfaction. They also longed for some modification in their body if opportunities could be available. On the other hand, the high scorer male and female participants reported an overall positivity, satisfaction and love towards their body. In addition, they did not desire to make any change in their body. The major theme emerged after the thematic analyses were:

Positive Affection, love and respect towards body: Most of the participants expressed positive feeling, love, affection and satisfaction toward their body. One male participant expressed as *“I respect my body and its parts because these give me immense pleasure and satisfaction in all respect. The illness is the major hurdle for maintaing positive body image.”* In her interview, a female participant expressed herself as *“I like my body very much because oveall it is my body.”* The positive body image also gave self-respect and confidence. The positive body image has also been found to generate happiness.

1. **Positive Cognitions:** The participants have shown positive attitudes, decisions and positive evaluations towards their body and its parts in spite of some lacks. One male participants expressed himself as *“My body makes me successful*

and it works well. I can work for long hours without any rest. Whenever I think about my body, it makes me happy. It is better than my friends' body." One female replied as *"My body helps me to achieve the goals of my life. It is attractive and other people also extend positive comments for my body."* The positive body image has reported to initiate optimism. The participants were also found to be aware about their less attractive body attributes. They all showed a high acceptance and defensive attitude towards such attributes.

2. **Gender differences in Positive Body Image:** The male and female participants unequivocally pronounced that male and female differ in their body attributes. The female participants put importance on body structure and positive social impacts whereas males gave importance to muscular strength, vigour and stamina in comparison to females. One male participant commented as *"My muscles are my beauty and other things do not matter for me. It can generate fear in the mind of my friends."* One female replied as *"My hairs, nose and colour of my body are attractive. These help to attract people of any age. A good body should be beautiful not very strong"*.

3. **Major Correlates of Positive body Image:** The thematic analyses evinced that all the participants gave weightage to socioeconomic factors, heredity, media, personality, psychological attributes, life satisfaction, optimism, social skills, leadership, age, gender, culture, race and regular exercise as the major antecedents and correlates of positive body image. One male expressed himself as *"It is the money, genetic heritage and gender which actually determine ones body image."* The female participants emphasized more on wealth and social status and personality in the determination of ones positive body image. One female said as *"With the help of money, one can become physically good and attractive"*. The major activities that determine ones positive image are regular exercise, balanced diet

and good relations. The participants accepted the role of media in shaping their positive body image.

4. **Spiritual/ Religious Component:** All the participants agreed that observing the spiritual and religious activities enhance one's positive body image. Some participants expressly said that God made them beautiful and good. One male said as "*It is the God who has given everything and my body also. I am no one to evaluate it negatively*". The Yogic practices and other religious ceremonies help to achieve positive body image. One female replied as "*Mother Goddess has given all of us good body. All of us are beautiful.*"

5. **Health, Well-being and other Outcomes:** Majority of the participants showed consensus that positive body image has direct linkage to good physical and mental health. It made them happy, active and energetic for long. Good employment and business successes were said to be associated with the positive body image. Some accepted it to be a good reason to become successful in academic areas. The emotional and adjustment of the participants were found to be directly linked to their level of positive body image.

DISCUSSION

The results of the study demonstrated that positive body image and gender of the participants shaped the nature and extent of the general health of the participants. The female participants exhibited higher mean scores on positive body image and general health measures as compared to their male counterparts. It should be kept in mind that the higher scores of general health symbolized lower general health and the lower scores indicated better general health, the negative correlations exhibited that the higher scores of positive body image was indicative of better general health. The socioeconomic status, health awareness, easy availability of mass media, educational opportunities and adoption of good health habits and care from the parents might

be some of the reasons behind the higher positive body image of the female students. There was statistically significant gender difference in positive body image of the male and female participants. Due to enhanced awareness and globalization, Indians also have become particular about their body image which has resulted in strong socialization in the Indian community favoring adolescents and adults for ideal shape of their body (Shah, Shaikh & Singh, 2012). These researchers also emphasized parental role in maintaining positive body image.

The results also evinced negative correlation between the scores of positive body image and general health of the male and female participants. In addition, the regression analyses showed that 5.8% of the variance in the scores of general of the male participants was predicted by their positive body image whereas 4% of the variance in general health of the female participants was caused by their scores of positive body image. The pooled data also indicated 3.7% of the variance in general health accounted for by their positive body image. These results have important implications for research and practice. The persons with positive body image have a positive feeling and respect for their body, like to engage in exercise and feel satisfied, take or understand the importance of balanced diet which result in their good general physical and mental health. Such things were reported by the participants in qualitative study also.

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with positive body image have a positive feeling and respect for their body, like to engage in exercise and feel satisfied, take or understand the importance of balanced diet which result in their good general physical and mental health. Such things were reported by the participants in qualitative study also.

The results of the qualitative study showed that the low achievers on positive body measure had expressed some minor concerns about the attributes of their body and showed some body dissatisfaction and they also longed for some modification in their body. On the other hand, the high scorer participants reported satisfaction and love towards their body with the desire of no change in their body. Positive affection, love and respect towards body, positive cognitions, gender differences in positive body image, major correlates of positive body image, spiritual/religious component and health, well-being and other outcomes were the major themes emerged after the thematic analyses of the qualitative data. Most of the participants expressed positive feeling, love, affection and satisfaction toward their body with self-respect, confidence and happiness. The participants have shown positive attitudes, decisions and positive evaluations towards their body and its parts in spite of some lacks. The positive body image was also reported to nurture optimism. The participants were also found to be aware about their less attractive body attributes. They all showed a high acceptance and defensive attitude towards such attributes.

The male and female participants unequivocally pronounced that male and female differ in their body attributes. The female participants put importance on body structure and positive social impacts whereas males gave importance to muscular strength, vigour and stamina in comparison to females. The participants accepted the role of socioeconomic factors, heredity, media, personality, psychological attributes, life satisfaction, optimism, social skills, leadership, age, gender, culture, race and regular exercise as the major antecedents and

correlates of positive body image. Regular exercise, balanced diet and good relations are the major activities in which the persons with high positive image remain involved. The participants accepted the role of media in shaping their positive body image. All the participants agreed that observing the spiritual and religious practices enhance ones positive body image. Majority of the participants showed consensus that positive body image has direct linkage to their good physical and mental health. The attractive employment and business successes were said to be associated with positive body image. Some accepted it to be a good reason to become successful in academic areas. The emotional and adjustment of the participants were found to be directly linked to their level of positive body image.

Thus, results of the present study empirically demonstrated that positive body image has important implications in general health and other aspects of human functioning and performance. Positive self-concept, motivation and positive cognitions are some of the characteristic features of the individuals with high positive body image. It was shown that positive body image has also important implications for academic success and achievements. Previous studies have exhibited that the nature of the body image is important for people of all age groups bearing important and long-term mental and physical health outcomes (Figueiredo, Cullen, Hwang, Rowland & Mandelblatt, 2004; Jain & Tiwari, 2016; Tiwari, 2014). The positive body image can be viewed as the major protective factor for adolescents and adults to face adversities in the crises of their lives. The conclusions provide a base for recommending policy makers to incorporate body image awareness programme in existing physical and mental health services and projects for all age groups.

Implications and Directions for Future Research

The results of this study have significant implications for interventions to improve adherence to positive health behaviors.

Obesity has become a big problem of our society and excessive use of technology has been resulting into poor health outcomes, obesity; eating disorders etc. Media is playing a vital role in the development of individuals' body image by portraying an ideal image that most of the people strive to achieve. The striving for ideal body has compelled the people engage in unhealthy behaviors like dieting, excessive exercising, surgical treatment and many other body alteration activities. The findings of the study would entail noteworthy theoretical and practical implications for the researchers, clinicians, government health policy makers, health professionals and administrators. The conclusions of the study will help people to choose their careers, develop personality, recover from illness, help tool development and also assist in furthering the research in the area of positive body image. In addition, the results of the study will also be helpful in the field of psychotherapy and counseling to develop intervention programmes for helping those having negative body image or other kind of body related problems. The body image constitutes an important non-academic self-concept along with mental health which has been reported to shape the academic success and performance of the adolescents and adults (Gujare & Tiwari, 2016). The yoga and yogic exercises have been reported to have positive impacts on the mental and physical health of the individuals (Tiwari, 2016). Thus, it has significant implications in academic area also. The small sample, limited area of study and lesser number of variables are some of the important limitations of the study. The researchers are advised to generalize the findings carefully. Future researchers may involve large sample with diverse age groups and apply Mixed Methods Design and longitudinal approach in their studies to have a better understanding of the dynamics of positive body image and general health.

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Conflicts of interest

The authors have no conflict of interest with anyone.

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Internet Addiction: Can Cognitive Behaviour Therapy Help?

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ABSTRACT

The Internet is one of the most impressive and the most useful technological advancements that the human race has known. It grants the user a vast amount of knowledge and skills that can be utilized at any given time and at any given place, making it a very powerful tool in the hands of productive individuals. Internet savvy individuals are able to keep in touch with friends, perform financial transactions, shop and perform multiple tasks, all from the comfort of one's home. The most intriguing aspect of the Internet is that all of the above mentioned tasks can be performed simultaneously. This very fact highlights the amount of control the Internet puts into the hands of individuals who know how to utilize it effectively. The main aim of this review was to understand Internet addiction as a mental health problem and the effectiveness of Cognitive Behaviour Therapy as a treatment strategy to help tackle addiction to the Internet. Based on the findings of the articles reviewed in the current study, it

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was found that CBT and a form of CBT specifically designed for Internet addiction (CBT-IA) are standard and effective ways of treating Internet addiction.

Keywords: *Internet Addiction, Cognitive Behaviour Therapy, CBT-IA*

Internet Addiction: What it is and why we should be concerned.

Internet addiction refers to a state wherein individuals tend to lose control over their online activities, as a result of which they continue using the internet in spite of negative and problematic outcomes that affect major areas of their lives (Chao & Hsiao, 2000; Young & Abreu, 2011). It can also be viewed as a pathological and compulsive usage of the Internet. It is considered to be a form of impulse control disorder. Despite the many positive uses that the internet provides us with, its negative uses are far more damaging and problematic. The vast availability of the internet is perhaps its most dangerous aspect, as individuals would prefer to spend time online even when surrounded with family members or close friends. They are unable to connect with people in the real world, and hence prefer the company of like minded individuals online. Internet abuse is also found to impact marital relationships and family life to a great extent (Kwiatkowska et al., 2007). Internet addiction has also been proved through various studies to have negatively impacted academic and vocational life (Young, 1998).

Presence of Internet addiction is often accompanied by certain noteworthy neurological changes (Dong et al., 2010; Liu et al., 2010; Park et al., 2010). Individuals with Internet addiction have been found to report abnormal brain activation (Kim et al., 2012). Internet addiction also reduces striatal dopamine transporters (Hou et al., 2012) and associate strongly with dopaminergic brain systems dysfunctions (Yen et al., 2012), indicating that it has a serious impact on the functioning of the

brain. A study by Lin et al. found that individuals with Internet addiction had reductions in fractional anisotropy (FA) in white matter pathways throughout the major areas of the brain. This abnormal white matter structure was thought to be linked to various behavioural impairments. These findings are indicative of the fact that Internet addiction is a disorder grave enough to impact even the physiology of the brain.

Increasing prevalence of internet addiction is now a global phenomenon. It is not uncommon to see individuals engrossed on their mobile phones sending chat messages to friends and family, posting updates about their lives on social networking platforms, sending out important emails and performing vital financial transactions. With more and more people turning to the internet for their varied needs, the number of internet addicts is on the rise as well. India is not an exception to this rule. With the telecom companies offering high speed broadband plans at fairly reasonable rates, the Internet is now becoming more affordable and accessible than ever before. Characteristics of Internet addiction such as ignorance of work, loss of sleep, higher loneliness and increased duration of time spent online have already been observed and found among research studies in India (Nalwa & Anand, 2003). A report by the Internet and Mobile Association of India (2015) has stated that there were close to 87 million Internet users in rural India in the year 2015 and it also predicted that this number would rise about 500 million by the year 2018. This staggering number is indicative of how many people are going to be able to access the internet in the near future, and how many more vulnerable individuals would turn into Internet addicts.

Risk Factors of Internet Addiction

Although an increasing number of individuals are now turning to the internet for their varied needs, it is only a few of them who would actually end up getting addicted to the Internet.

Similar to other mental health problems, Internet addiction also has a few risk factors, the presence of which makes an individual more vulnerable to this disorder.

Presence of Internet addiction has been found to have comorbidity with other forms of mental health issues such as aggression (Lim et al, 2015; Yen et al, 2007), depression (Gamex-Guadix, 2014; Yen et al, 2007), loneliness (Karapetsas, Karapetsas, Zygouris, & Fotis, 2015; Ozdemir, Kuzucu, & Ak, 2014), social anxiety (Weidman et al, 2012; Sepehrain, F., & Lotf, J. J., 2011), and mental disorders like schizophrenia and OCD (Ha et al., 2006). It has also been found to share a high comorbidity with other forms of addictions like substance use and alcohol addictions (Yen et al, 2009).

When it comes to an individual's gender, various research studies have found contradictory results. Some research studies have found that males are more likely to develop Internet addiction (Okwaraji, Aguwa, Onyebueke & Shiweobi-Eze, 2015), while there are others who have found no difference related to gender in this context (Kim et al, 2006). Males could be more technologically oriented and hence, they probably spend more time in front of gadgets like laptops and cell phones as compared to girls. However, recent merging of gender roles and increase in technical knowledge among both genders has reduced the gender divide when it comes to usage of hi-tech gadgets. This finding could eliminate the possibility of one gender being more prone to Internet addiction than the other. Teenagers have also been found to be particularly more vulnerable to Internet addiction as compared to other age groups. Owing to easy access to the internet at home or school/college, spare time at hand and also peer pressure, adolescents are often found to be using the internet more frequently (Madell & Muncer, 2004; Suss, 2007).

Types of Internet Addiction

Usage of the term ‘Internet addiction’ or ‘Problematic Internet Usage’ is often used generically, without considering the content that the Internet is being used to access. The Internet is merely a medium through which addicts would try to satiate their real life addictions. What fuels an online addiction is the false sense of anonymity and security that addicts believe the Internet provides them with. Secondly, the Internet is now an affordable and easily accessible technology, increasing the chances that it will be overused (Griffiths, 2000; 2012). Discussed below are the major types of Internet addiction based on the content being consumed (Young, 1999).

1. Cybersexual addiction: It refers to engaging in online sexual activities such as pornography, adult website surfing and sexting.
2. Cyber-relationship addiction: It refers to excessive usage of social networking and chatting websites to socialize with others.
3. Net Compulsion: This type of addiction refers to excessive involvement in online shopping, gambling and gaming.
4. Information overload: It refers to engaging in excessive online database searching or web browsing.
5. Computer addiction: Computer addiction refers to an obsession with the offline games like solitaire, minesweeper and free cell.

Diagnostic criteria of Internet addiction

Having mentioned the types of Internet addiction, it is not uncommon for individuals to diagnose themselves as Internet addicts based on the content of their Internet usage. Almost all individuals may have engaged one or more of the above mentioned online content. But that very fact does not make an individual an Internet addict. As any other form of mental disorder, certain symptoms that are characteristic of Internet

addiction have been identified and enlisted in order to aid the process of distinguishing normal Internet usage from Internet overuse.

The addition of 'Internet addiction' in the Diagnostic Statistical Manual of Mental Disorders (DSM) has long been debated by mental health professionals. The development of the proposed diagnostic criteria for Internet addiction has been under progress since the past few years. Owing to a lack of sufficient and significant literature on the topic, Internet addiction was unable to find a place in the DSM-IV- TR. The following criteria have been proposed by Dr. Kimberly Young (1999) for identifying Internet addiction.

1. Preoccupation with Internet usage
2. Experience of tolerance.
3. Recurrent failed attempts at reducing/stopping Internet usage
4. Experience of withdrawal symptoms
5. Using the Internet for a longer duration than planned
6. Negative impact on major life areas (home, school/work, friends)
7. Deceiving family, friends and significant individuals in the real world about the time spent online as well as the activities done online.
8. Using the Internet as an escape from real world problems or as a mood alleviation technique.

Shapira et al (2003) suggested broader, systematic categorization in the form of Criteria A, B and C, wherein Criteria A included presence of preoccupation with the Internet or usage of Internet for longer than intended, Criteria B included functional impairments and Criteria C comprised on exclusionary diagnosis. Along similar lines, the 'Diagnostic Criteria for Internet Addiction among Taiwanese Adolescents' (DC-IA-A) was also crafted by Ko et al. (2009). This is the most

popular and widely used diagnostic criteria for Internet addiction in Taiwan. Hsu et al (2015) conducted a thorough examination of the DC-IA-A through expert validation from twenty psychiatrists. Through their study, they established that even these criteria needed revision, as few of the items were not applicable in recent times. A major breakthrough in the field of categorization and classification of Internet addiction came in the form of inclusion of the sub-type of Internet addiction, namely Internet Gaming Addiction, in the DSM-V (American Psychiatric Association, 2013).

Having established the fact that Internet Addiction is a serious hazard to mental health, it is also important to consider the possible intervention strategies that could help in its treatment. There are many interventions put forth by clinical practitioners, however this paper focuses only on the efficiency of Cognitive Behaviour Therapy with Internet Addiction.

Cognitive Behaviour Therapy

The effectiveness of Cognitive Behaviour Therapy (CBT) while treating various emotional and behavioural problems can be affirmed by the fact that many therapists have turned to it and also sworn by it since the past 50 years. The popularity of behavior therapy in the 1950s and cognitive therapy in the 1970s, and the insight that their integration could yield much better results led to the formation of Cognitive-Behaviour treatments. The behavioural aspect of CBT works by increasing adaptive behaviours by rewarding them with positive reinforcement and minimizing problem behaviours by reducing reinforcement for them. The cognitive aspect focuses on tackling faulty thoughts and information processing patterns which are found to be an integral part of mental health problems. CBT focuses on how individuals think, feel and behave. It involves usage of only those techniques that have been proven effective through scientific research. The integration of cognitive and behaviour

combines the strengths of both the approaches to aid the understanding and treatment of various mental health issues (Hazeltt-Stevens & Craske, 2002).

According to Cognitive-Behaviour Theory, people have unique ways of looking at the same situation. People are also very selective of the interpretations about themselves that they develop based on inputs they receive from others. A problem occurs when these cognitions and interpretations are faulty or distorted. Individuals may often not even be aware of these dysfunctional thoughts as they are automatic in nature. CBT focuses on helping the individual to recognize these automatic thoughts and challenge them. It involves a collaborative effort from both the therapist as well as the individual undergoing therapy. The therapy proceeds in a manner so as to help the individual to think in new ways and solve problems by themselves (British Columbia Ministry of Health, 2007).

CBT is planned in such a way so as to target specific problem behaviours that the therapist would identify as part of the presenting problem. The assumption here is that once the target behavior is dealt with, the resulting problem behaviours and cognitions would also consequently change. Another premise of CBT is that maladaptive behaviours that occur due to faulty learning can be corrected through relearning of adaptive behaviours (Hazeltt-Stevens & Craske, 2002). On an average, CBT requires about 3 months of treatment, during which the early stages are focused on targeting specific behaviours and situations in which the disorder is the most unmanageable. Gradually, the focus of therapy shifts to cognitive issues that cause problematic behavior to emerge. A budding and promising approach in CBT is utilization of mindfulness techniques as a vital part of therapy. These techniques employ Buddhist meditation techniques in the therapeutic process. The aim of therapies based on this technique is to change the context in

which faulty and irrational thoughts occur (Hockenbury, Nolan, & Hockenbury, 2015).

Effectiveness of CBT with Mental Health Issues

CBT has been found to be effective with many forms of mental health issues, ranging from day-to-day adjustment disorders, to the more serious neurotic, psychotic and mood disorders. Research studies have found CBT to be fairly effective in treatment of eating disorders (Agras et al, 2000; Pike et al, 2003; Wilson, 2005). When it comes to neurotic disorders, the effectiveness of CBT has been affirmed in the treatment of anxiety (Beck, Emery, & Greenberg, 2005), OCD (Cottraux et al, 2001; Foa et al, 2005; McLean et al, 2001) and Phobias (Krijn, Emmelkamp, Olafsson, & Biemond, 2004; Öst, Svensson, Hellstorm & Lindwall, 2001; Rothbaum, Hodges, Smith, Lee, & Prince, 2000). During the treatment of neurotic disorders, the main focus is on monitoring one's own anxiety, learning relaxation techniques and coping strategies, and using various cognitive strategies to make thoughts and perceptions more accurate and adaptive (British Columbia Ministry of Health, 2007).

CBT has also been proved to be effective in the treatment of depression (Barbe, Bridge, Brimaher, Kolko, & Brent, 2002; Young, Rygh, Weinberger, & Beck, 2008). CBT helps depressed individuals establish and structure their daily activities, and it also helps the person challenge typical negative thoughts associated with depression. CBT aids in shifting focus from physical symptoms and negative mood which are symptomatic of depression (British Columbia Ministry of Health, 2007). CBT has also been found to be effective in the treatment of Bipolar disorder (Scott, 2004; Scott, Garland, & Moorhead, 2001).

In the context of psychotic disorders, research has found that CBT can aid with schizophrenic individuals by reducing delusions and hallucinations as well as other psychotic symptoms

by helping them to examine the reality of their dysfunctional thoughts and perceptions (Morrison et al, 2014). CBT has also been found to improve vital cognitive functions such as attention, problem solving and social skills among schizophrenics (Bowie et al, 2014; Kurtz & Richardson, 2012). It is used with individuals who have been stabilized through the use of anti-psychotic medications. It has also been found to reduce relapse rates of psychotic episodes (British Columbia Ministry of Health, 2007).

CBT has also been found to be effective for substance use disorders (Dutra et al, 2008). In these cases, treatment involves assessment of the individual's motivation to change, collaborative therapeutic agreement, developing coping skills and alternatives to usage of addictive substances, identifying and managing high-risk situations, identifying the emotional and cognitive cues that are associated with substance usage, and making attempts at relapse prevention and maintenance of change even after completion of the therapy. These aspects are usually achieved through aversion therapy, anger management, exposure and response prevention, relaxation therapy and stress management (British Columbia Ministry of Health, 2007).

CBT with Internet Addiction

Having established the effectiveness of CBT with the most commonly occurring mental health disorders, verifying its effectiveness with Internet addiction can also be considered. According to cognitive-behavioural theorists, Internet addicts often possess a maladaptive thought process such as overgeneralization, negative core beliefs, catastrophizing and cognitive distortions that could push the addict towards abuse of the internet as a form of avoidance or escape strategy from real world problems (Young, 2007).

CBT has been found to be a widely accepted and markedly effective intervention technique when it comes to

Internet addiction. Most commonly, treatment for Internet addiction revolves around conscious use of the Internet for productive activities instead of leisure activities, development of offline activities, self-management and self-restraint, self-observation, strengthening of interpersonal communication, psycho-education, behavior modification, shaping, modeling, reinforcement, problem solving skills, coping-strategies training, support groups and journal keeping (Hockenbury, Nolan, & Hockenbury, 2015; Lemos, Abreu, & Sougey, 2014, Young, 2007). The main goal of therapy is not complete abstinence from the Internet, as that would be impractical given our current Internet dependent lifestyle. The goal of therapy is to manage one's Internet usage in a way that is adaptive and fruitful, which is referred to as Conscious Computing (Greenfield, 2008).

Internet addicts who undergo CBT as a therapeutic intervention have been found to show better recovery as compared to addicts who receive no form of intervention (Du, Jiang & Vance, 2010; Li & Dai, 2009). CBT has been found to help Internet addicts manage their addiction in merely two months of receiving therapy and maintaining the therapeutic goals even after six months of completion of therapy (Young, 2007). CBT also helps addicts manage and control the duration of time that they spend online as well as aiding in the reduction of emotional, behavioural and cognitive symptoms that are typical of Internet addiction (Du, Jiang, & Vance, 2010). In order to enhance the effectiveness of CBT, it is also often paired with other forms of intervention. When compiled with Motivational Interviewing, CBT was found to have very successful results, wherein the addicts who completed treatment successfully were able to limit the time they spent online and also exhibited increased confidence levels (Rooij, Zinn, Schoenmakers, & Mheen, 2012). A combination of CBT with electroacupuncture (passage of a small electrical current between acupuncture needles) has also been found to show very effective results as a

treatment strategy for Internet Addiction (Zhu, Jin, & Zhong, 2009). The combination of CBT with bupropion (a drug useful as an antidepressant and for smoking cessation) was found to increase life satisfaction scores on the one hand and reduce Internet addiction scores on the other (Kim, Han, Lee, & Renshaw, 2012). Przepiorka, Blachnio, Miziak & Czuczwar (2014) have recommended a blend of CBT and forms of pharmacotherapy such as Citalopram, Bupropion, Methylphenidate and Memantine as an efficient treatment strategy for Internet Addiction.

Young (2011) developed a specialized form of CBT called the Cognitive-Behavioural Therapy for Internet Addiction (CBT-IA), which was designed specifically for the treatment of Internet addicts. The initial phase of this therapy focuses on the examination of computer behaviour and non computer behaviour, wherein computer behaviour deals with actual online usage aimed at abstinence from problematic online content and controlled usage of productive online activities. Online and offline time management is considered to be the initial goal of CBT-IA. The second phase is essentially of a cognitive nature, aimed at tackling denial and faulty cognitions that rationalize excessive online usage. CBT-IA employs cognitive restructuring as a way to challenge Internet addicts to re-script negative thought patterns and analyze how rational and valid their interpretations of their environment are. Helping addicts gain insight into their problem enables them to challenge their faulty cognitions by themselves. The third phase involves the utilization of Harm Reduction Therapy (HRT) that helps with recovery and relapse prevention. It focuses on co-existing psychiatric, social, familial and occupational issues. Young (2013) conducted a study to examine the practical effectiveness of CBT-IA and found that the Internet addicts that underwent this treatment were better able to stick to their structured Internet

usage schedules, were more productive at work and/or school and also showed improvements in their close relationships.

CONCLUSIONS

Increase in the number of individuals who are using the internet and the resulting increase in the number of individuals who end up abusing the Internet cannot be denied. The number of Internet users in India is also on the rise. Hence, it is of vital importance to bring awareness among the masses about the possibility of getting addicted to the Internet, as well as its negative impact on significant life areas. The current study also examined the efficiency of Cognitive Behaviour Therapy as an intervention strategy for Internet Addiction. CBT has been proved to be effective for the treatment of Internet addiction through various research studies. This finding is especially useful for mental health professionals, especially in India where the number of Internet users and Internet dependents is rising every day. It was also found that CBT is more effective when combined with other forms of treatment. Another significant finding was the establishment of the CBT-IA as an effective way of treating Internet addiction. Future studies should aim to conduct studies wherein the effectiveness of the CBT-IA is tested on Indian population, the results of which would help practitioners and psychologists adapt it according to the Indian scenario.

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Role of Mushroom in Maintaining Mental Health with Special Reference to Anti-Convulsant Activity

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ABSTRACT

Various mushroom proteins, such as lectins, fungal immunomodulatory proteins, ribosome inactivating proteins, ribonucleases, laccases and other proteins have interesting biological activities. These have become popular sources of natural antitumor, antiviral, antimicrobial, antioxidative and immunomodulatory agents. This paper updated the present status of bioactive compounds in *Ganoderma lucidum* a mushroom with biomedical potential. *Ganoderma lucidum* collected from botanical garden growing on *Mimosops elangi* as pathogen was investigate for the bioactive compounds and anticonvulsant activity. Its aqueous extract was injected in wistar albino rats. Phytochemical analysis was done by chemical, FTIR and mass spectrometric methods. Acute toxicity was determined using Lorke's method. The anticonvulsant activity of the extract was assessed in pentylenetetrazole (PTZ) induced and maximal

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electroshock (MES) induced convulsion in rats, with valproic acid and phenytoin as positive control (PC), respectively. Gamma amino butyric acid (GABA) estimation of rat brain was carried out by standard high performance liquid chromatography (HPLC). Phytochemical analysis showed the presence of polysaccharides, flavonoids, terpenoids and phenolic acids in particular. Six bioactive compounds were identified in GAE by FTIR and LC-MS characterization which included three triterpenoids and three phenolic compounds/flavonoids. Extracts were found non-lethal even at the doses over 5000 mg/kg intraperitoneally. GAE at higher dose (500mg/kg) and PC produced nearly similar effects (100% protection) against MES induced generalized tonic hind limb extension (THLE) and PTZ induced absence seizures. GAE showed significant effects against both convulsion models in a dose dependent manner. None of the deaths were recorded in MES rats while in PTZ rats higher doses of test reduced mortality to 16% along with the valproic acid, which also produced 16% deaths. GABA content was also found improved in test groups and standard in PTZ rats. GABA appeared non-essential in MES induced convulsions. These results suggest that *Ganoderma* aqueous extract possess anticonvulsant potential due to the presence of biologically active components.

Keywords: *Polypore Mushrooms, Ganoderma Lucidum, Trametes Hirsuta, Epilepsy, Mental Health.*

Mushrooms have become attractive as a well balanced food and pharmaceutical stuff with some advantages over plants providing definite nutrition and health benefits for human. Traditionally, wild and cultivable edible mushrooms are used by most of the Asian and other countries worldwide as good source of pharmacologically active compounds (1). Wild and cultivated

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mushrooms are rich in dietary fiber, minerals, and vitamins and low in fat (2). Over the past several decades, scientific research has been intensified and focused on analyzing varied nutritional and medicinal properties of mushrooms. Elaborative studies report that mushrooms accumulate variety of secondary metabolites, including phenolic compounds, polysaccharides, terpenoids and steroids responsible for the enormous therapeutic activities. They are consistently being studied for their immense pharmacological properties which include hepatoprotective (3), immune-modulating (4), neuroprotective (5), anticancer (6), antidiabetic (7), antimicrobial (8), antiviral (9), and antioxidant (10; 8) activities. *Ganoderma* (Curtis) P. Karst is a polyporous medicinal mushroom belonging to family Ganodermataceae, predominantly found on broad leaved tree trunks and dead stumps in Central Indian sub-tropical forests (11,12). *Ganoderma lucidum* commonly known as Lingzhi or Reishi contains biologically active components like triterpenoids, polysaccharides, ganoderic acids and phenolic compounds and so on. Substantial reports are available in literature indicating vast array of pharmacological effects of *Ganoderma* species conferred by its bioactive components. There are several reports regarding the central nervous system (CNS) protective effects of *Ganoderma* (13; 14; 15).

Very little is known about ameliorative effects of *Ganoderma* against epilepsy. Epilepsy is a central nervous system disorder characterized by recurrence of paroxysmal neurological or behavioral manifestations commonly termed seizures. Seizures or convulsions result from chronic imbalance between excitatory and inhibitory neurotransmitters leading to hyperexcitable neuronal discharges. For the management of epilepsy a good number of antiepileptic drugs (AEDs) available but far from adequate. Hence, research is needed to find AEDs of natural origin with no side effects. In this context, present study

was aimed at phytochemical characterization and antiepileptic effects of aqueous extract of *Ganoderma lucidum* (GAE) using different experimental models *in vivo*. In our previous work, we found higher antioxidative effects of its ethanolic extract using *in vitro* methods (10). It is supposed that aqueous extract of the mushrooms contain phenolic compounds and terpenoids which may have antioxidant and anticonvulsant potential.

MATERIALS AND METHODS

Sampling and extraction

Ganoderma lucidum fruiting bodies were collected in June-August (monsoon), 2012 from sub-tropical deciduous forests of Madhya Pradesh (Central India). *Ganoderma* was isolated from living *Mimusops elengii* tree parasitically causing basal stem rot in it. The specimens were photographed, soft brush cleaned, taken to Laboratory of Microbial Technology and Plant Pathology, Department of Botany, Dr. H. S. Gour University Sagar, M. P. for identification and authentication. A specimen voucher MTPP11/45 of the sample was deposited in herbarium of the department. The fruiting bodies were dried in an oven at 40 °C for 8 hours. The dried fruiting bodies were crushed to powder by using REMI electronic blender. About 50g powder of the mushroom was taken in 500ml of distilled water in soxhlet extraction unit for extraction at 100 °C for 16-18 hours. The *Ganoderma* aqueous extract (GAE) was then rotary evaporated at 60 °C, kept in a dessicator to dry and stored at 4 °C for further use.

Chemicals

GABA, Sodium Valproate, Phenytoin and Pentylene tetrazole were purchased from Sigma-Aldrich Co (Mumbai). All other unlabeled chemicals and reagents were of analytical grade.

Preliminary Phytochemical Analysis

Phytochemical tests were carried out on the rotavaporised extract using standard procedures as described by Harborne (19).

Fourier Transform Infra Red (FTIR) spectroscopy studies

FTIR spectroscopy of the extract was tested using high sensitive FTIR Spectrometer (Shimadzu 2191, Japan). Briefly one part of sample was mixed with 99% of dried potassium bromide powder (KBr). This mixture was subjected to FTIR spectrum analysis in the frequency range of 400 to cm^{-1} 4000.

Liquid Chromatography-Mass Spectrometric (LCMS) studies

Phytochemical characterization was further done by separating the components of GEE and TEE by HPLC module (Agilent Technologies) with Autosampler G1329B injection volume 5 μl , Quaternary Pump G1311C flow rate 0.5ml/min, Solvent A H₂O with 0.1% formic acid: Solvent ACN (85:15) for a runtime of 35 minutes and Thermostat Column Compartment G1316A with a C18 reversed phase column. The column eluate was passed into the Electro Spray Ionisation (ESI) interface operating in negative and positive modes of Agilent Technologies MS QQQ Mass Spectrometer. The voltage on the ion spray interface was 4000 V and the fragmentor voltage of the orifice was set at 130V-150V. Selected (M+H⁺) or (M-H⁻) ions were analyzed by collision induced dissociation using nitrogen as the collision gas. MS2 scan type in both negative and positive polarities, scan time 500, analyzing the mass in the range of 100-1600 m/z were recorded.

Experimental animals

Wistar Albino rats of either sex (weighing 100-150 g) were obtained from Department of Research and Defence Organisation (DRDO), Gwalior. The animals were maintained in a well-ventilated room, fed on standard pellet feed and water *ad libitum*. All studies on animals were approved by Institutional Animal Ethics Committee (IAEC).

Acute Toxicity Study

Toxic effects of the extracts were analysed using the method of Lorke (25). The method consisted of two phases. In the first phase, three groups of three rats each were injected with GAE at doses of 10, 100 and 1000 mg/kg body weight IP and observed for signs of toxicity and death within 24 h. In the second phase, four groups of one rat each were treated with four more specific doses of the extract based on the result of the phase first. Finally, two doses of the extract were chosen on the basis of acute toxicity studies for anticonvulsant activity.

Anticonvulsant activity

Maximal electroshock-induced convulsion in rats

The method described by Swinyard and Kupferberg (26) and modified by Sayyah et al. (27) was further modified and used in this study. Briefly, 24 wistar albino rats were randomly divided into four groups containing 6 rats. The first group (control) received normal saline 10 ml/kg body weight IP, second group (standard) was injected with 20 mg/kg of the standard drug phenytoin, third (GAE250) and fourth (GAE500) groups were treated with 250 and 500 mg/kg of GAE intraperitoneally. Thirty minutes later, maximal electroshock was administered to induce seizure in the rats in all groups using an electroconvulsometer with corneal electrodes placed on the upper eyelid of the rats. The shock duration, frequency, current were set and maintained at 1.5 s, 150 pulse/sec and 50 mA, respectively. Seizures were manifested as tonic hind limb extension (THLE) and duration of whole episode (28). The ability to prevent this feature or reduce the duration of the convulsion was considered as an indication of anticonvulsant activity (29).

Pentylenetetrazole (PTZ) induced convulsion in rats

In this study, animals (N=24) were divided in four groups of six animals each. Grouping was done as: first group as control

received normal saline (NS) and PTZ (80 mg/kg i.p.), second group as positive control (PC) received NS + Valproic acid (30 mg/kg i.p.), third group (GAE250) received NS + GAE (250 mg/kg i.p.), and fourth group (GAE500) received NS + GAE (500 mg/kg) intraperitoneally. Pentylenetetrazole (PTZ 80mg/kg) was administered to all groups 30 minutes after receiving treatments to induce clonic convulsions. For a period of 30 minutes post-PTZ administration animals were observed for onset of convulsion and duration of convulsion. Incidence and mortality % due to PTZ were also recorded.

Gama amino butyric acid (GABA) estimation

Shortly after the observation animals were sacrificed, and brains removed and submerged in ice-cold artificial cerebrospinal fluid. The brain tissue (1mg) was washed with saline to remove blood, blots to dry and submerged in 10 ml methanol. Subsequently, homogenized for 2 minutes and centrifuged at 10000 rpm for 15 minutes. 1 ml of the supernatant of the brain homogenate was mixed with 1 ml of water and centrifuged at 12000 rpm for 10 minutes. Afterwards 0.7 ml of the supernatant was added to a volumetric flask containing 0.6 ml of borax buffer (pH 8). The mixture was heated on water bath at 800 C for 10 minutes. Final volume of the flask was adjusted to 5 ml with methanol. 5 ul of the membrane filtered solution was injected in C18 column (HPLC Alliance Waters, Millford USA; separation module 2965 coupled to Waters 2998 Photodiode array detector DAD Milford, MA USA; Waters Spherisorb reversed phase-C18 analytical column (250 mm × 4.6 mm i.d., 5 µm; ODS2) and eluted with methanol and water (62:38 v/v), flow rate 1 ml/min. The chromatograms were plotted at 330 nm. HPLC system control and data processing was performed by Empower software (Build 2154, Waters). The retention time of the sample was compared with that of the standard GABA. GABA in brain was quantified in terms of

ng/mg brain tissue by plotting a standard curve of GABA (24, 25).

Statistical Analysis

The data were subjected to one-way analysis of variance (ANOVA) followed by *post hoc* Duncan's multiple comparison test and Students t-test wherever applicable (SPSS 16.0 version). Comparison where $P < 0.05$ was considered as statistically significant. Standard curves were plotted in MS Excel 2007 for the matter of convenience.

RESULTS

Preliminary Phytochemical analysis and yield percentage

The extraction carried out by soxhlet unit result a yield of 62 per cent of the dry powder of GAE. Soxhletation was done at higher temperatures so as to extract maximum number of the secondary metabolites present in the mushroom. Aqueous extract of the mushroom have shown the presence of various secondary metabolites expected in good concentrations as indicated by the yield percentages presented in Table 1.

FTIR studies

FTIR spectroscopy is currently used to investigate the vibrations of molecules and polar bonds between different atoms on the basis of wave number of bands. The absorption intensity can be used for calculating the relative concentration. In the present study, FTIR spectra of GAE are shown in Fig. 1. The typical signal pattern expected for phenolic compounds and several bands in other regions are present.

Signals acquired from FTIR (Fig. 1) were prominent and intense at the wave numbers ($1/\text{cm}$) 1350-1470 (variable; bending) corresponding to alkanes, 1500 and 1600 (weak; stretch) corresponding to aromatic rings, 1640-1680 (weak, medium; stretch) corresponding to alkenes, 1670-1760 (strong; stretch) indicating the presence of aldehydes, ketones, carboxylic

acids and esters, 2500-3000 (broad; stretch) corresponding to carboxylic acids, 2850-2960 (strong; stretch) as alkanes and 3200-3600 (broad; stretch) corresponding to alcohols and phenols. Therefore, from these signals it can be interpreted that both the extracts contain polysaccharides, flavonoids and other phenolic compounds in essential thus partially supporting the preliminary phytochemical analysis.

Mass spectrometric characterization of GAE

The extract was analyzed by LC-MS which provided sufficient data for tentative component identification. The molecular mass information of components and formation of adducts were obtained. Their molecular weights ranged from 200 Da upto 1000 Da which clued that compounds were mainly flavonoids, phenolic compounds and terpenoids. Compounds which have been tentatively identified on the basis of m/z values, formation of adducts, neutral losses and protonated molecular masses are presented in Figure 2 (A,B,C,D,E,F).

Anticonvulsant activity

MES induced convulsions

All the control animals after delivering electroshock to them exhibited seizures, loss of righting reflex with tonic forelimb and hindlimb extension, flexor, clonus and stupor phases of the convulsion. The duration of THLE and whole convulsive episode including flexor, clonus and stupor are presented in Figure 3 and 4. Lower doses of GAE showed insignificant reduction and at higher concentrations were found much more effective ($p < 0.001$) against THLE and convulsion induced by MES when compared with control. At 500 mg/kg dose GAE nearly abolished tonic hind limb extension in rats as that of positive control (PC), Phenytoin sodium. No mortality was observed in any of the rats delivered MES. However, incidence of seizures was found to vary in different groups of MES animals (Table 2).

PTZ induced convulsions

The results showed that i. p. administration of GAE led to a significant delay ($p < 0.001$) in the onset of PTZ induced myoclonic absence seizures. At lower and higher doses both the mushroom extracts have shown significant reduction in the duration of the seizures Figure 5 and 6. Mortality per cent was reduced by PC and GAE500. In PC and GAE500 groups, 50% of animals showed incidence of seizures. Lower dose treatments of mushroom extracts and Control showed 100 % incidence each (Table 2).

HPLC determination of GABA

HPLC provided a convenient method for the determination of GABA content in brain tissue by plotting area units (AU) versus concentration of standard GABA (fig. 7). In MES assay, none of the groups showed any significant variation in GABA concentrations. Results presented in (table 2) have shown increase in the GABA levels (ng/mg wet tissue) of treated animals only in PTZ assay. GAE at higher doses showed significant increases in GABA level when compared with control (0.064 ng/mg).

DISCUSSION

The powdered fruiting bodies of mushroom were extracted with ethanol in soxhlet apparatus unit in order to obtain higher yields and maximum number of bioactive principles accumulated by the mushroom. Consequently, percentage yields were higher and phytochemical characterization was able to provide thorough information regarding the identification of bioactive compounds. For the last two-three decades, hyphenated instrumentation like LC-MS, GC-MS, LC-NMR have been implemented on a large scale to get clear insights in the identification of secondary metabolites from natural sources. Preliminary phytochemical analysis in present

study was further supported by FTIR and LCMS in the identification of compounds present in aqueous extracts of *Ganoderma* mushrooms. The compounds reported here have been tentatively identified on the basis of FTIR signals, m/z ratios, formation of product ions and adducts, and molecular mass of the compounds in particular by matching them with the previously reported compounds, Mass Bank Database, Phenol explorer and Dictionary of natural products. Although available literature reports the presence of huge array of compounds (polysachharides and terpenoids in particular) in *Ganoderma* species (26, 27, 28), there is indeed deficient work indicating flavonoids and other phenolic compounds in *Ganoderma*. We report here identification of flavonoids, phenolic compounds, and terpenoids as well on the basis of FTIR and LC-MS characterization. Triterpenoids and steroids have been reported to possess anticonvulsant activity (29). Thus, our study is assumed a primary step in characterizing the compounds present in the GAE extract.

Acute toxicity study (ATS) showed that lower (250 mg/kg) and higher (500 mg/kg) concentrations of GAE did not produce toxic or lethal effects; hence no mortality was seen during ATS.

The present study demonstrates that aqueous extract of mushroom have its effects against acute seizures triggered by GABA receptor antagonist (PTZ) and glutaminergic excitation inducers (maximal electro shock, MES) and, lipid peroxides produced in seizure induced tissue. Chemical seizure model induced by PTZ represents a valid and widely accepted model for generalized myoclonic and absence seizures. PTZ may cause seizures by inhibiting chloride channel associated with GABA_A receptors (30, 31). Contrarily, MES test is considered as a characteristic physical model for generalized tonic-clonic seizures (32).

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In this study, GAE had protective effects in above mentioned models of epilepsy. Phenytoin is one of the drugs effective at blocking seizures induced by MES. It is established that drugs like phenytoin display high affinity in blocking MES-induced seizures due to their greatest affinity at blocking voltage-sensitive sodium channels. It is possible that GAE also showed similar effects by modulating the voltage gated sodium channels. While GAE showed its dose dependent protection against THLE and duration of the MES induced seizure, at higher dose GAE presented much pronounced effect against THLE than those of vigabatrin (2000mg/kg), an established AED (33). However, protection determined against THLE could not be explained on the basis of GABA levels of brain tissue in MES model. Following high dose PTZ (80 mg/kg) induced myoclonic and petit mal (absence) seizure types in all the animals. The PTZ model has been known to lead the discovery of the anticonvulsant drug valproic acid. It is also known that AEDs like valproic acid have the propensity to block PTZ-induced seizures due to their action on GABA_A receptors or block thalamic T-type calcium ion channels. GAE extract significantly delayed the time for the onset of seizure and appeared to be more effective against PTZ-induced seizures. GAE at both doses prolonged the latency to onset and reduced the duration of the seizure. *G. lucidum* extracts reported in earlier studies inhibited sympathetic nerve activity in anaesthetized animals (34), elevated pain threshold, prolonged death time induced by caffeine, and relaxed skeletal muscle in mice (35). Furthermore, it has been shown to improve the insomnia severity scores in patients with neurasthenia (36). GAE produced the latency to onset and reduction of the duration in a dose dependent manner. The critical role of GABAergic stimulation of brain cells has been well established. Enhanced levels of endogenous GABA during epileptic absence seizures acts as a defence mechanism to

terminate ongoing seizure activity. Valproic acid is known to exert its anticonvulsant effect by interacting with voltage dependent Na^+ channels in addition to the GABA mediated inhibition (37,38). Hence, the protective effects of the mushroom GAE and higher dose in particular could be explained on the basis of elevated endogenous GABA concentration which abolished seizures. It is notable from the results that in MES none of the deaths were observed, while in PTZ higher doses of GAE protected more than 50% animals from epileptic mortality. Both mushroom extracts being efficacious in MES and PTZ models reflect potential pharmaceutical applications for grand mal (THLE) and petit mal (absence) seizures.

The anticonvulsant efficacy of the test mushroom could also be explained on the basis of presence of phytochemicals like polysaccharides, terpenoids and flavonoids and their derivatives revealed by mass spectrometry. Extensive work on anticonvulsant potential of these bioactive compounds has been carried out (39). Nevertheless, flavonoids have been mostly linked to the anticonvulsant effects (40, 41). Recently, Jager and Saaby (42) have reviewed the protective role of flavonoids like apigenin, quercetin, kaempferol, rutin, naringenin, hesperidin, epicatechin and their derivatives in various central nervous system (CNS) disorders. As per the review, the flavonoids present in food and medicinal plants are consumed by humans; upon absorption aglycones and conjugates of flavonoids pass through the blood brain barrier. Furthermore, certain classes of flavonoids and their glycosides bind to benzodiazepine sites on the $GABA_A$ receptor thus producing anticonvulsant and central depressant effects (43, 44, 45). As per our results, GAE500 in particular is likely to abolish convulsions due to the binding of some bioactive flavonoids to benzodiazepine sites or elevating GABA concentrations thereby inhibiting hyperexcitation of neuronal discharges. Present state of knowledge of chemical

constituents do not allow to attribute with certainty its anticonvulsant effect of any of the compounds identified herein the study. It is worthy to isolate the bioactive principles which are responsible for these activities, if this study is assumed to be a preliminary step.

CONCLUSIONS

It is clear from the study that test mushroom extracts showed protective effects against PTZ and MES seizure models which are widely used to determine the anticonvulsant activity in vivo. Though GAE have the anticonvulsant potential at lower doses but higher produced much pronounced effects against both types of convulsions. Polysaccharides, terpenoids, and flavonoids were identified by advanced techniques which could be possibly responsible for the activities. It is supposed to be a novel study in that *Ganoderma* has never been demonstrated to have anticonvulsant activity though a huge number of bioactive compounds have been isolated and identified in mushroom extracts. Furthermore, *Ganoderma* has been characterized for the first time and a number of flavonoids could be identified tentatively along with a thoroughly studied biological activity. However, more extensive studies are suggested to evaluate the precise mechanism of the bioactive compounds responsible for the anticonvulsant activity.

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TABLES AND FIGURES

Table 1: Yield percentage and Phytochemistry of the GAE

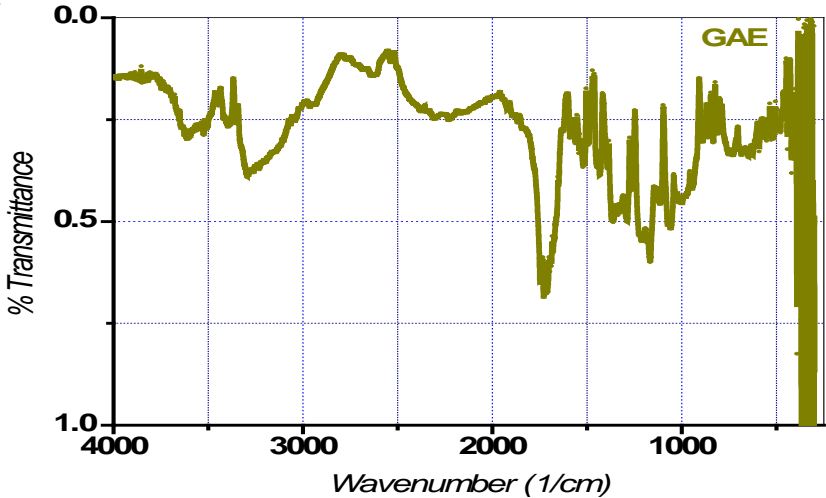
Extract	Yield percentage	Polysaccharides	Alkaloids	Steroids	Terpenoids	Flavonoids	Saponins	Anthocyanins	Phenolic acids
GAE	62%	+	-	-	+	+	-	-	+

+ present; -- absent; GAE *Ganoderma* aqueous extract

Table 2: Seizure Incidence, Mortality and GABA content of animals with different treatments.

PTZ Groups	Incidence	Mortality (%)	GABA content	MES Groups	Incidence	Mortality (%)	GABA content
NS	0	0	0.254	NS	0	0	0.254
NC	6/6	66.6	0.064	NC	6/6	0	0.040
PC	3/6	16.6	0.181	PC	6/6	0	2.1
GAE250	6/6	50.0	0.126	GAE250	6/6	0	1.4
GAE500	3/6	16.6	0.172	GAE500	6/6	0	0.091

Fig. 1: FTIR showing the presence of carbonyl compounds in particular



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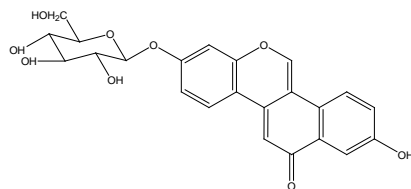
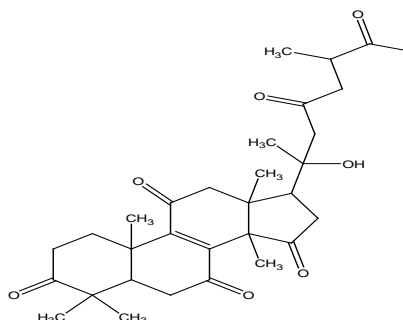
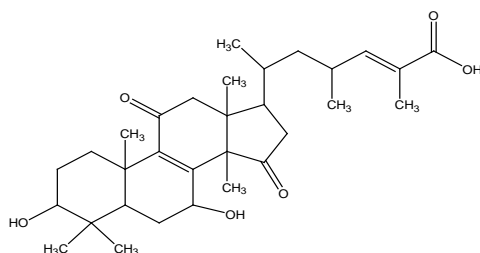
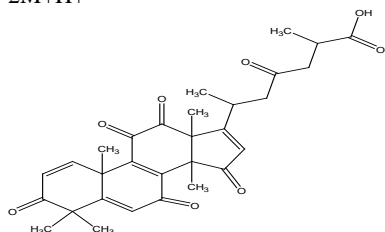


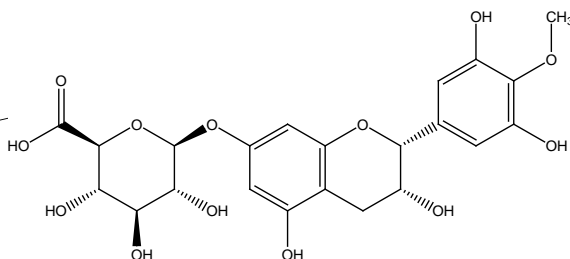
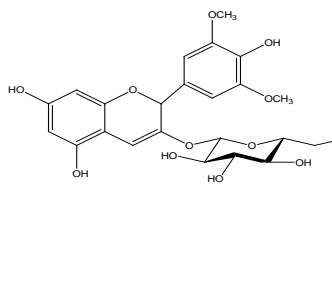
Fig. 2: LCMS characterization of the extract. A,B,C,D,E and F are compounds identified in the aqueous extract GAE on the basis of molecular ion peaks $M+H^+$, $M+Na$, $2M+Na$ and $2M+H^+$

(A) 12-Hydroxy-3, 7, 11, 15, 23-pentaoxolanost-8-en-26-oic acid. $m/z = 528.20$



(B) 7, 4'-Dihydroxyisoflavone 7-O-glucoside; $m/z=416.2$

(C) 3, 7, 11, 12, 15, 23-Hexaoxolanost-8-en-26-oic acid; $m/z=526.20$

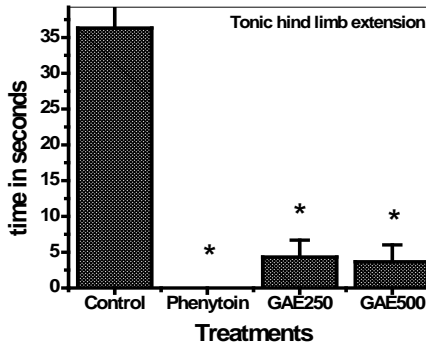


(D) 3, 7, 15-Trihydroxy-11, 23-dioxolanosta-8, 20 (22)-dien-26-oic acid; $m/z = 512.20$

(E) Malvidin 3-O-glucoside ($C_{23}H_{25}O_{12}$); $m/z = 493.20$

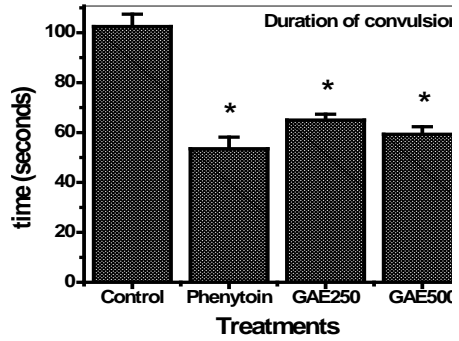
(F) 4'-O-Methyl(-)-epigallocatechin 7-O-glucuronide ($C_{22}H_{23}O_{13}$); $m/z = 496.20$

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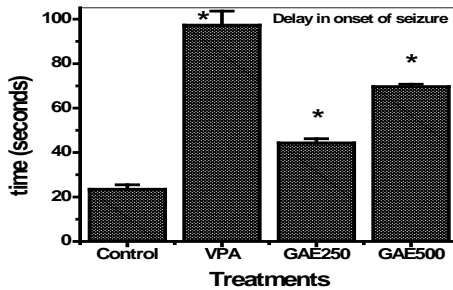
Values are mean \pm s.d.; * p <0.001

Fig. 3: Protective effect of GAE on MES induced tonic hind limb seizures in rats.



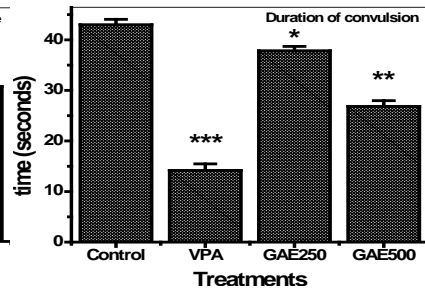
Values are mean \pm s.d.; * p <0.0001

Fig. 4: Protective effect of GAE on MES induced duration of convulsion in rats.



Values are mean \pm s.d.; * p <0.001

Fig. 5: Protective effect of GAE as delay in onset on PTZ induced seizures in rats.

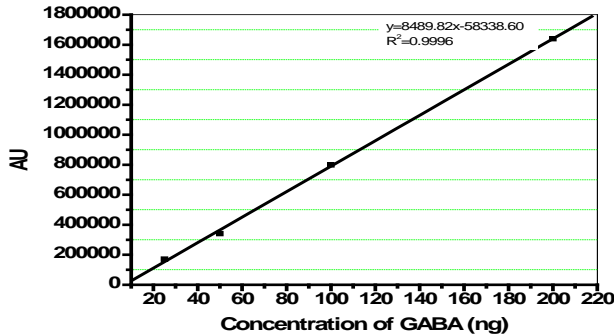


Values are mean \pm s.d.;

* p <0.05, ** p <0.01, *** p <0.001

Fig. 6: Protective effect of GAE as duration of convulsion on PTZ induced seizures in rats.

Fig. 7: GABA standard curve



Mental Health Symptoms Predict Academic Achievement of the Female Students

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ABSTRACT

The present study attempted to assess the role of mental health symptoms in predicting and shaping the academic achievement of the female graduate students. A two hundred and thirty nine females studying in undergraduate courses belonging to high ($M = 18.76$, $SD = 1.63$), middle ($M = 18.59$, $SD = 1.43$), and low ($M = 18.32$, $SD = 1.00$) socioeconomic status (SES) Maged 16 to 24 years took part in the study whose mental health symptoms, socioeconomic status (SES) and academic achievement were measured by standardized psychometric tools. The results of the study revealed that emotional problems, conduct problems, hyperactivity and peer problems components of mental health symptoms have negative correlations with the scores of academic achievement of the participants whereas the scores of pro-social behaviour component of mental health symptoms of the female students exhibited a positive correlation with the scores of

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academic achievement. The high, middle and low socioeconomic status of the participants affected their mental health symptoms and academic achievement. The regression analyses showed that the mental health symptoms predicted the academic achievement of the participants. Thus, mental health symptoms and socioeconomic status of the female participants have significant implications for the academic achievement of the students. The results of the study have significant theoretical and practical implications for developing an understanding of the dynamics of academic achievement of the students. The results of the study have been discussed in the light of current theories and findings of mental health and academic success of the students. The conclusions of the study will help the educationists, researchers, academicians, education policy makers and public at large to understand the role of mental health in shaping the academic achievement of the students. The suggestions for future researchers have also been discussed.

Keywords: *Mental Health Symptoms, Emotional Problems, Conduct Problems, Hyperactivity, Peer Problems, Pro-Social Behaviour, Academic Achievement, Socioeconomic Status.*

Quite a good number of researchers exhibited that there is a significant relationship among academic self-concept, academic motivation, and academic achievement (Marsh, Byrne, & Shavelson, 1988; Valentine, DuBois, & Cooper, 2004). Initially, researchers of self-concept confined themselves on the contribution of global self-concept to academic outcomes and empirical examination of model of Shavelson, Hubner and Stanton (1976) which suggested significant but modest correlations between global self-concept and grades for both children and adolescents (Marsh, 1990). An intensive examination revealed negligible impact of combined effects of

global and academic self-concepts on academic outcomes (Marsh & O'Mara, 2008). It was also confirmed in a study of Marsh and colleagues (2008) in which a longitudinal associations among global and academic self-concepts for a sample of 2213 10th grade boys at 5 time points (early 10th grade, late 11th grade, high school graduation, 1 year post-graduation, and 5 years post-graduation) were observed. The researchers looked the other aspect of self-concept i. e. non-academic self-concept, to explain the academic achievement of the students.

In recent years, non-academic self-concept has received greater attention by the researchers who have found it useful in explaining not only academic success but also functioning of the students in the other areas. According to Suntonrapot, Auyporn, & Thaweewat (2009), it has the ability to produce causes not only in the academic setting but also outside the classroom. It is able to provide more important information than academic self-concept for improving students' skills, characters, social, behavior and academic achievement. The importance of non-academic self-concept is further highlighted by Williams (1993) who has observed that the role of non-academic self-concept in academic achievement has been underestimated by the researchers. Williams (1991) studied the relative influence of self-concept and test anxiety on the academic achievement of 116 high school students. He reported that test anxiety and self-concept had independent influences on achievement of the students. The high achieving students were reported to had fewer cognitive concerns about testing, perceived themselves to be competent and sought to be more dependable whereas low-achieving students were high in test anxiety, perceived themselves to be dependable and sought to be more social (Williams, 1991).

The results of the studies reported a dependable relationship between non-academic self-concept and academic

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achievement (Hasenzadeh, Hussini, & Moradi, 2004; Suntonrapot et al., 2009). The findings by Chong (2007) also reported a positive correlation between non-academic self-concept and academic achievement but the relationship is weak for children in remedial classes as compared to students in normal classes. Some studies contradicted with these findings and came to the conclusion that non-academic self-concept is a negative predictor of academic achievement (Sánchez & Roda, 2003). In the same line, another study reported no relationship between non-academic self-concept and academic self-concept with academic achievement (Marzuki, 2002).

The mental health symptoms, an important component of non-academic self-concept, have been reported to impact academic achievement of preschool children (Arnold, 1997) and adolescents (Eisenberg, Golberstein, & Hunt, 2009). Preschool children exhibiting externalizing disorders (attention deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder) were found to show lower grades in school as compared to their peers, as well as higher rates of grade repetition, aggression and school dropout. The early childhood teacher ratings of externalizing behavior were reported to be correlated strongly with delinquency (Hinshaw, 1992). In addition, aggression was more likely to result in joining special education programs or lower grade by children after controlling for IQ (Hinshaw, 1992).

The results of a longitudinal study of a large sample of children exhibiting parent-reported depression and anxiety at age six to eight were less likely to graduate high school after controlling for race, gender, SES, and maternal factors (Breslau, Lane, Sampson, & Kessler, 2008; McLeod & Kaiser, 2004). A study by Cole, Martin, Peeke, Seroczynski, and Fier (1999) reported in their longitudinal study of eight hundred seven 3rd and 6th grade students that anxiety and depression shaped their

academic self-concept and resulted into them feeling less competent academically. It is suffice to conclude that mental health symptoms and other components of non-academic self-concept have a meaningful association with the self-concept of the students and significant impact on the academic performance also. Many studies revealed associations between low global self-concept and internalizing disorders, particularly depression and suicidal ideation, in children and adolescents (Dumont & Provost, 1999; Harter, 1993). Recent studies, however, have questioned these findings and came to the conclusion that while low global self-concept correlates with depression, the direction of causality remains unclear (Baumeister, Campbell, Krueger, & Vohs, 2003). The specific sub-domains of self-concept have been reported to show significant correlation than global self-concept with mental health symptoms (Bidell & Deacon, 2010).

Thus, previous researches demonstrate that low academic self-concept predicts poor academic achievement, mental health disorders also predict poor academic achievement, global self-concept relates to both academic self-concept and mental health symptoms, sub-domains of self-concept show stronger associations than global self-concept to academic outcomes and associations between sub-domains of the self-concept may not be as limited as earlier research suggested (Ogle, Frazier, Nichols-Lopez & Cappella, 2016). The research suggests that even brief interventions that target non-academic sub-domains of self-concept can improve academic and mental health outcomes for adolescents and adults, effectively leveraging prior findings regarding the reciprocal influence of self-concept on functional outcomes, and suggesting that different sub-domains may influence each other more than previously believed (Cohen, Garcia, Apfel, & Master, 2006). Thus, it is evident from the review of literature that there is dearth of studies showing the impacts mental health symptoms on the academic achievement

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of the students. In this backdrop, the present study aims to study the impacts of mental health symptoms and socioeconomic status on the academic achievement of the female graduate students.

Objectives

1. To study the impacts of the components of the mental health symptoms on the academic achievement of the participants, and
2. To inquire into the nature of the socioeconomic status differences in mental health symptoms and academic achievement of the participants

Hypotheses

1. The female participants with high, middle and low socioeconomic status will differ in their mean scores on emotional problems, conduct problems, hyperactivity problem, peer problems and pro-social behaviour mental health symptoms and academic achievement.
2. The emotional problems, conduct problems, hyperactivity problem and peer problems components of mental health symptoms will show negative correlations whereas pro-social behaviour will indicate a positive correlation with the academic achievement of the female students.
3. The high, middle and low socioeconomic statuses, emotional problems, conduct problems, hyperactivity problem, peer problems and pro-social behaviour mental health symptoms will predict academic achievement of the female students.

METHODS AND PROCEDURE

A correlational design was used in the present study. The stratified sampling procedure was employed to select the sample from science, arts and commerce departments of Dr. H. S. Gour University, Sagar, M. P. and Government (Autonomous) Girls P. G. College of Excellence, Sagar, M. P.

Sample

Two hundred and thirty nine regular female undergraduate students aged 16 to 24 years belonging to high, middle and low socioeconomic status served as the participants in the study. Out of two hundred and thirty nine participants, 41.84%, 43.10 and 15.06 belonged to high, middle and low socioeconomic levels, respectively. The students were pursuing undergraduate programmes in arts, commerce and science streams. The consent was sought from the principal and heads of the concerned departments before the start of the study. The students with no known prior history of physical and mental illnesses were included in the study.

Tools

Following psychometric tools were employed in the present study:

- 1. Strength and Difficulties Questionnaire (SDQ):** The Hindi translation of the SDQ (Goodman, 1997), a well validated and widely used self-report measure of psychopathology, was employed to screen out the students for mental health symptoms and impairment in five sub-domains: emotional difficulties (corresponding to internalizing symptoms), conduct problems, hyperactivity, peer problems and pro-social behaviour). It consists of 25 items with three alternatives i.e. 0–2 (not true, somewhat true and certainly true). It has shown validity in multiethnic samples i.e. majority and minority populations (Hill & Hughes, 2007). Its scores correspond to the mental health symptomatology construct in the theoretical model. The internal consistency by Cronbach alpha and retest stability estimates of reliability have been reported to be .73 and .62, respectively (Goodman, 2001).
- 2. Socioeconomic Status Scale:** Socioeconomic Status scale standardized by Aggarwal et al., (2005) on Indian population

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was used to assess the socioeconomic status of the participants. The scale consists of 22 items with multiple choice answers. It categorizes the individuals and families into six categories such as Upper High >76, High 61-7), Upper Middle 46-60, Lower Middle 31-45, Poor 16-30 and Very Poor or Below Poverty Line <15. It has been widely used in behavioural sciences research.

- 3. Academic Outcome:** The marks obtained by the students in their examination of last academic class were used as an index of their academic achievement.

Procedure

After having been planned and procured the required tools as per the design, the sample was selected for the study. It was divided into twelve groups comprising twenty participants each for the convenience of administering the tools. Before conducting the actual study, an integrated strategy was developed and a thorough study of the questionnaires and other details including the precautions and instructions was read and understood. The researchers read the instructions aloud along with the pace of the participants to control the time of presentation of each item of the scales. As per the formulated plan of the study, the various scales were administered and the scoring was carried out as per the guidelines depicted in the manuals. The raw scores so obtained were arranged as per the design of the study. With the completion of the task of data collection, the same were treated with the help of SPSS (Statistical Package for the Social Sciences), a software programme to analyze the data. The data were treated with mean, standard deviations (SDs), t-test, Pearson Product Moment correlation and regression analysis statistics.

RESULTS

The results of the study demonstrated that the participants with high socioeconomic (SES) status demonstrated average higher score on emotional problems ($M = 3.55$, $SD = 2.16$) as compared to the female participants of middle ($M = 3.41$, $SD = 1.90$) and low ($M = 3.44$, $SD = 2.08$) socioeconomic status. For the conduct problems, the middle SES participants ($M = 2.99$, $SD = 1.76$) indicated higher mean score as compared to high ($M = 2.85$, $SD = 1.68$) and low SES ($M = 2.31$, $SD = 1.62$) participants. Likewise, the participants from middle SES ($M = 3.24$, $SD = 1.68$) showed higher mean score on hyperactivity as compared to high ($M = 3.06$, $SD = 1.66$) and low SES ($M = 2.83$, $SD = 1.70$) participants. Contrary to this, the female participants from high SES ($M = 3.49$, $SD = 1.52$) showed higher mean score on peer problems as compared to the middle ($M = 3.10$, $SD = 1.53$) and low SES ($M = 3.42$, $SD = 1.86$) participants. On the pro-social behavior dimension of mental health symptoms, the female participants from lower SES ($M = 8.75$, $SD = 1.56$) showed higher mean score as compared to high ($M = 8.42$, $SD = 1.50$) and middle SES ($M = 8.32$, $SD = 2.10$) participants.

Table 1: Mean scores and SDs of emotional problems, conduct problems, hyperactivity, peer problems and pro-social behaviour and academic achievement scores of the high, middle and low SES female participants

S. No.	Measures	High SES			Middle SES			Low SES		
		Mean	SD	N	Mean	SD	N	Mean	SD	N
1.	Emotional Problems	3.55	2.16	100	3.41	1.90	103	3.44	2.08	36
2.	Conduct Problems	2.85	1.68	100	2.99	1.76	103	2.31	1.62	36
3.	Hyperactivity	3.06	1.66	100	3.24	1.68	103	2.83	1.70	36
4.	Peer Problems	3.49	1.52	100	3.10	1.53	103	3.42	1.86	36
5.	Pro-Social Behaviour	8.42	1.50	100	8.32	2.10	103	8.75	1.56	36
6.	First four Combined	12.95	5.40	100	12.74	4.86	103	12.00	5.19	36
7.	Marks (Aca. Ach.)	67.31	9.99	100	67.19	10.72	103	63.81	12.45	36

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When the data of emotional problems, conduct problems, hyperactivity and peer problems of the female participants arranged in three socioeconomic classes, the female participants from high SES ($M = 12.95$, $SD = 5.40$) showed higher mean score on peer problems as compared to middle ($M = 12.74$, $SD = 4.86$) and low SES ($M = 12.00$, $SD = 5.19$) participants. The marks of the female students of their last examinations were treated as the index of their academic achievement. The average academic achievement score of the females from high SES ($M = 67.31$, $SD = 9.99$) was higher as compared to the middle ($M = 67.16$, $SD = 10.72$) and low SES ($M = 63.81$, $SD = 12.45$) participants.

The results of t-test indicated that the female participants of high SES ($t = 1.80$, $df = 35$, $p = .05$) differed significantly to those of low SES participants on emotional problems dimension of mental health symptoms. Likewise, these two groups also significantly differed in their mean scores on hyperactivity ($t = 2.64$, $df = 35$, $p = .01$) and when the scores of the first four dimensions were combined except pro-social dimension ($t = 3.07$, $df = 35$, $p = .004$). In addition, the participants of high and middle SES females differed significantly in their mean scores on peer problems ($t = 2.19$, $df = 99$, $p = .03$). The mean scores on academic achievements of the high and low SES female participants also demonstrated statistically significant difference ($t = 2.05$, $df = 35$, $p = .05$). The rest of the high, middle and low SES comparison groups did not show statistically significant differences in their mean scores on the emotional problems, conduct problems, hyperactivity problems, peer problems and pro-social behaviour dimensions of mental health symptoms and academic achievement.

The scores of the mental health symptoms and academic achievement of the students were pooled and their mean standard deviations were computed. The female participants exhibited

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lower mean score on conduct problems ($M = 2.83$, $SD = 1.72$) followed by hyperactivity ($M = 3.11$, $SD = 1.67$), peer problems ($M = 3.31$, $SD = 1.58$), pro-social behaviours ($M = 3.31$, $SD = 1.58$) and emotional problems ($M = 3.47$, $SD = 2.03$). The average academic achievement score of the participants was ($M = 66.73$, $SD = 10.73$). The total acquired scores on all the five dimensions of mental health symptoms were compared with the help of t-test which demonstrated that the participants differed in their acquisition of mean scores on emotional problems and conduct problems ($t = 4.86$, $df = 238$, $p = .000$), emotional problems and hyperactivity problems ($t = 3.02$, $df = 238$, $p = .003$), emotional problems and pro-social behaviour ($t = 26.77$, $df = 238$, $p = .000$) but did not differ significantly on emotional problems and peer problems ($t = 1.17$, $df = 238$, $p = .244$). The scores of the first four dimensions i. e., emotional problems, conduct problems, hyperactivity problems and peer problems were pooled and its mean score was compared with the mean score of the pro-social behaviour component which also evinced significant difference ($t = 11.24$, $df = 238$, $p = .000$).

Table 2: The Coefficients of correlation among the scores of five components of mental health symptoms and academic achievement of the high, middle and low SES female participants

Dimensions of Mental Health Symptoms and Academic achievement	High SES		Middle SES		Low SES	
	r	p	r	p	r	p
Emotional Problems-Percentage of Marks	-.105	.300	-.025	.803	-.389	.019
Conduct Problems-Percentage of Marks	-.165	.102	-.075	.451	.204	.232
Hyperactivity-Percentage of Marks	-.185	.065	.119	.233	.034	.846
Peer Problems-Percentage of Marks	-.016	.874	.121	.222	-.045	.896
First four Combined-Percentage of Marks	-.155	.125	.042	.673	-.097	.575
Pro-Social Behaviour-Percentage of Marks	.071	.480	.022	.823	-.054	.754

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The coefficients of correlations were computed which exhibited that there were negative correlations among the scores of emotional problems ($r = -.012, p = .064$), conduct problems ($r = -.048, p = .460$), hyperactivity ($r = -.007, p = .916$) and pro-social behaviour ($r = -.005, p = .943$) whereas the scores on peer problems component of mental health symptoms showed a slight positive correlation with the scores of academic achievement ($r = .033, p = .615$). The data were also treated in terms of the socioeconomic status of the participants i. e. high, middle and low SES. The results indicated that emotional problems ($r = -.105, p = .300$), conduct problems ($r = -.165, p = .102$), hyperactivity ($r = -.185, p = .065$) and peer problems ($r = -.155, p = .125$) were negatively correlated with the scores of academic achievement whereas pro-social behaviour evinced a positive correlation of ($r = .071, p = .480$) with the academic achievement of the high SES students. In case of the students of middle SES, the negative correlations were found among the scores of emotional problems ($r = -.025, p = .803$) and conduct problems ($r = -.075, p = .451$) with the scores on academic achievement. Contrary to this, hyperactivity ($r = .119, p = .233$), peer problems ($r = .121, p = .222$) and pro-social behaviour ($r = .005, p = .943$) indicated a slight positive correlations with the academic achievement of the middle SES students. The scores of emotional problems ($r = -.389, p = .019$), peer problems ($r = .045, p = .896$) and pro-social behaviour ($r = .054, p = .754$) of low SES participants indicated negative correlations with the scores of academic achievement whereas conduct problems and ($r = .204, p = .232$), hyperactivity ($r = .034, p = .846$) showed slight positive correlations. The details have been displayed in Table 2.

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Table 3: Regression analysis of scores of emotional problems, conduct problems, hyperactivity, peer problems and pro-social behaviour and academic achievement of the female students in terms of their socioeconomic status.

S. No.	Dimensions of Mental Health Symptoms	High SES					Middle SES					Low SES				
		R	R ²	R ² Δ	F	p	R	R ²	R ² Δ	F	p	R	R ²	R ² Δ	F	p
1.	Emotional Problems	.105	.011	.011	1.087	.300	.025	.001	.001	.063	.803	.389	.151	.151	6.056	.019
2.	Conduct Problems	.165	.027	.027	2.731	.102	.075	.006	.006	.573	.451	.204	.042	.042	1.482	.232
3.	Hyperactivity	.185	.034	.034	3.490	.065	.119	.014	.014	1.439	.133	.034	.001	.001	.038	.846
4.	Peer Problems	.016	.000	.000	.025	.874	.121	.015	.015	1.510	.222	.045	.002	.002	.068	.796
5.	First four Combined	.155	.024	.024	2.397	.125	.042	.002	.002	.180	.673	.097	.009	.009	.321	.575
6.	Pro-Social Behaviour	.071	.005	.005	.403	.580	.022	.000	.000	.050	.823	.054	.003	.003	.100	.754

The scores were also treated with regression analysis assuming the five components of mental health symptoms and the three levels of socioeconomic status of the participants as the predictors and academic achievement as the criterion. The values of regression analyses have been put in Table 3 which shows that low scores on the various dimensions of mental health symptoms indicated better mental health and predicted 2% to 4% of the academic achievement of the female students irrespective of their socioeconomic status.

DISCUSSION

The results of the study evinced that the participants with high socioeconomic (SES) status demonstrated average high score on emotional problems as compared to the female participants of middle and low SES. For the conduct problems, the middle SES participants showed higher mean score as compared to high and low SES participants. Likewise, the participants from middle SES showed higher mean score on hyperactivity as compared to high and low SES participants. The female participants from high SES showed higher mean score on peer problems as compared to middle and low SES participants. On the pro-social dimension of mental health symptoms, the

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female participants from lower SES showed higher mean score on peer problems as compared to high and middle SES participants. When the data of emotional problems, conduct problems, hyperactivity and peer problems of the female participants arranged in terms of three socioeconomic classes, the female participants from high SES showed higher mean score on peer problems as compared to middle and low SES participants. The average academic achievement of the females from high SES was higher as compared to middle and low SES participants.

The results of t-test indicated that the female participants of high SES differed significantly to those of low SES participants on emotional problems dimension of mental health symptoms. Likewise, these two groups also significantly differed in their mean scores on hyperactivity and when the scores of the first four dimensions were combined except pro-social dimension. In addition, the participants of high and middle SES females differed significantly in their mean scores on peer problems. The mean scores on academic achievements of the high and low SES female participants also demonstrated statistically significant difference. The rest of the high, middle and low SES comparison groups did not show statistically significant differences in their mean scores on the emotional problems, conduct problems, hyperactivity problems, peer problems and pro-social behaviour dimensions of mental health symptoms and academic achievement.

The analysis of the pooled data showed that the female participants exhibited lower mean score on conduct problems followed by hyperactivity, peer problems, pro-social behaviours and emotional problems. The total acquired scores on all the five dimensions of mental health symptoms were compared with the help of t-test which demonstrated that the participants differed in their acquisition of mean scores on emotional problems and

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conduct problems, emotional problems and hyperactivity problems, emotional problems and pro-social behaviour but did not differ significantly on emotional problems and peer problems. The scores of the first four dimensions i. e., emotional problems, conduct problems, hyperactivity problems and peer problems were pooled and its mean score was compared with the mean score of the pro-social behaviour component which also evinced significant difference.

The negative correlations among the scores of emotional problems, conduct problems, hyperactivity and pro-social behaviour whereas the scores on peer problems component of mental health symptoms showed a slight positive correlation with the scores of academic achievement. In addition, the emotional problems, conduct problems, hyperactivity and peer problems were negatively correlated with the academic achievement whereas pro-social behaviour evinced a positive correlation with the scores of academic achievement of the high SES students. In case of the students of middle SES, the negative correlations were found among the scores of emotional problems and conduct problems and their scores on academic achievement. Contrary to this, hyperactivity, peer problems and pro-social behaviour indicated slight positive correlations with the academic achievement of the middle SES students. The scores of emotional problems, peer problems and pro-social behaviour of low SES participants indicated negative correlations with their scores of academic achievement whereas conduct problems and, hyperactivity showed slight positive correlations. The regression analyses showed that low scores on the various dimensions of mental health symptoms indicated better mental health and predicted 2% to 4% of the academic achievement of the female students irrespective of their socioeconomic status.

The results of the study evinced that in consonance with the hypotheses, mental health symptoms and socioeconomic

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status of the students were significantly associated with their academic achievement. Such results have also been recently reported in a study of Ogle et al. (2016). Most of the components of the mental health symptoms of the students indicated negative correlations except pro-social behaviours with the academic achievements. The socioeconomic status of the students also found to shape the academic achievement. The students who showed higher negative mental health symptoms also did poorer in their academic examinations. The results of the study also indicated that the gap in the socioeconomic status of the students determined and shaped their status of mental health that finally resulted into their particular levels of academic achievements.

The most important critical conclusion having significant theoretical and practical implications is that mental health symptoms have meaningful relevance for the academic performance for adolescents and adults. Such results have been reported for school children by previous researchers. The results of the present study are contradictory with the findings of the previous researches that had viewed academic self-concept as unrelated to the non-academic self-concept (Marsh & Shavelson, 1985) with no or limited impacts on the other components. The results support the arguments envisaged in the self-concept model of McConnell (2011) that conceived the mental health self-concept as a sub-domain helping the students perceive themselves relative to others and regulate their academic motivation, mental health, academic self-concept, engagement and study skills. Previous researchers have shown that the self-concept from mental health perspective assumed self-esteem or self-worth as vulnerabilities that correlate with depression and other disorders (Dumont & Provost, 1999; Harter, 1993; Marsh et al., 2004). Consequently, the mental health symptoms have been reported to be less useful in predicting academic achievement (Baumeister et al., 2003). Contrary to this

argument, the results of the present study evinced a significant association of mental health symptoms with academic achievement. It corroborates that mental health interventions can have an additive impact benefitting both school achievement and mental health of the students (Ogle et al., 2016). Thus, the results of the present study indicate a new area of research where the future researchers with distinct specialties such as clinical psychology, school psychology and social psychology can work together and collectively involve to understanding the dynamics of academic achievement and success.

IMPLICATIONS AND FUTURE DIRECTIONS

The focus of the present study was to develop a comprehensive understanding about the nature and dynamics of the academic achievement adapting mental health perspective. It helped to partial out the role of mental health symptoms and socioeconomic status in shaping the academic achievement of the participants. The results of the study have important theoretical and practical implications for researchers, academicians, policy makers, administrators and public at large. Its conclusions will help to understand the role of mental health perspective in the overall growth and development of the students of our country. It would also have important usefulness to the government policy makers to chart out plans to enhance achievement of the students adopting an eclectic perspective. Further, it would help the government policy makers to merge the mental health and educational plans together and enhance effectiveness of the both. Future researchers should carry out scientific studies involving self-esteem (Tiwari, 2011), non-academic self-concepts such as body image (Jain & Tiwari, 2016a; Jain & Tiwari, 2016b; Tiwari, 2014; Tiwari, Kumar, 2015), forgiveness (Mudgal & Tiwari, 2015), physical health (Tiwari, 2015), emotional intelligence Tiwari, 2016a), yoga and

mental health (Tiwari, 2016) along with mixed methods design to have a better understanding of the dynamics of academic success and achievement with mental health perspective hitherto a little known aspect of academic success.

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Intellectual Disability VS Mental Illness:

A Psychological Angle

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Keywords: *Intellectual Disability, Mental Illness, Mental Health, DSM*

In the upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the diagnosis of intellectual disability (intellectual developmental disorder) is revised from the DSM-IV diagnosis of mental retardation. The significant changes address what the disorder is called, its impact on a person's functioning, and criteria improvements to encourage more comprehensive patient assessment. The revised disorder also reflects the manual's move away from a multiracial approach to evaluating conditions. Using DSM-IV, mental retardation was on Axis II to ensure that clinicians identified associated impairments alongside other mental disorders. With DSM-5, all mental disorders will be considered on a single axis and given equal weight.

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Disorder Characteristics

Intellectual disability involves impairments of general mental abilities that impact adaptive functioning in three domains, or areas. These domains determine how well an individual copes with everyday tasks:

- The conceptual domain includes skills in language, reading, writing, math, reasoning, knowledge, and memory.
- The social domain refers to empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, and similar capacities.
- The practical domain centers on self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks. While intellectual disability does not have a specific age requirement, an individual's symptoms must begin during the developmental period and are diagnosed based on the severity of deficits in adaptive functioning. The disorder is considered chronic and often co-occurs with other mental conditions like depression, attention deficit/hyperactivity disorder, and autism spectrum disorder.

Name Change

Intellectual disability (intellectual developmental disorder) as a DSM-5 diagnostic term replaces “mental retardation” used in previous editions of the manuals. In addition, the parenthetical name “(intellectual developmental disorder)” is included in the text to reflect deficits in cognitive capacity beginning in the developmental period. Together, these revisions bring DSM into alignment with terminology used by the World Health Organization's International Classification of Diseases, other professional disciplines and organizations, such as the American Association on Intellectual and Developmental Disabilities, and the U.S. Department of Education.

A person with an intellectual disability may have problems expressing their thoughts, putting together sentences,

learning new skills, doing day to day tasks, making decisions, and remembering things. As a consequence when they experience a mental health issue it may not be recognized. Behaviours that may be associated with the presence of an intellectual disability may mask symptoms. In addition, medical practitioners or careers may assume that difficult behaviours are due to somebody's intellectual disability, instead of considering the possibility of mental health issues.

Getting the right support can also be difficult but there are many effective treatments. These treatments work best when there is good coordination between the mental health service provider and disability services.

Intellectual disability (ID), once called mental retardation, is characterized by below-average intelligence or mental ability and a lack of skills necessary for day-to-day living. People with intellectual disabilities can and do learn new skills, but they learn them more slowly. There are varying degrees of intellectual disability, from mild to profound.

Definition of Intellectual Disability:

Intellectual disability is a disability characterized by significant limitations in both **intellectual functioning** and in **adaptive behavior**, which covers many everyday social and practical skills. This disability originates **before the age of 18**.

What is intellectual Disability?

Someone with intellectual disability has limitations in two areas. These areas are:

- **Intellectual functioning.** Also known as IQ, this refers to a person's ability to learn, reason, make decisions, and solve problems.
- **Adaptive behaviors.** These are skills necessary for day-to-day life, such as being able to communicate effectively, interact with others, and take care of oneself.

IQ (intelligence quotient) is measured by an IQ test. The average IQ is 100, with the majority of people scoring between 85 and 115. A person is considered intellectually disabled if he or she has an IQ of less than 70 to 75.

To measure a child's adaptive behaviors, a specialist will observe the child's skills and compare them to other children of the same age. Things that may be observed include how well the child can feed or dress himself or herself; how well the child is able to communicate with and understand others; and how the child interacts with family, friends, and other children of the same age.

Intellectual disability is thought to affect about 1% of the population. Of those affected, 85% have mild intellectual disability. This means they are just a little slower than average to learn new information or skills. With the right support, most will be able to live independently as adults.

Mental Illness:

Mental illness is any disease or condition that influences the way a person thinks, feels, behaves, and/or relates to others and to his or her surroundings. Although the symptoms of mental illness can range from mild to severe and are different depending on the type of mental illness, a person with an untreated mental illness often is unable to cope with life's daily routines and demands.

What Causes Mental Illness?

Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many of these conditions are caused by a combination of genetic, biological, psychological, and environmental factors not personal weakness or a character defect and recovery from a mental illness is not simply a matter of will and self-discipline.

- **Heredity (genetics):** Many mental illnesses run in families, suggesting they may be passed on from parents to children through genes. Genes contain instructions for the function of

each cell in the body and are responsible for how we look, act, think, etc. However, just because your mother or father may have or had a mental illness doesn't mean you will have one. Hereditary just means that you are more likely to get the condition than if you didn't have an affected family member. Experts believe that many mental conditions are linked to problems in multiple genes not just one, as with many diseases. which is why a person inherits a susceptibility to a mental disorder but doesn't always develop the condition. The disorder itself occurs from the interaction of these genes and other factors such as psychological trauma and environmental stressors. which can influence, or trigger, the illness in a person who has inherited a susceptibility to it.

- **Biology:** Some mental illnesses have been linked to an abnormal balance of brain chemicals called neurotransmitters. Neurotransmitters help nerve cells in the brain communicate with each other. If these chemicals are out of balance or are not working properly, messages may not make it through the brain correctly, leading to symptoms of mental illness. In addition, defects in or injury to certain areas of the brain also have been linked to some mental conditions.
- **Psychological trauma:** Some mental illnesses may be triggered by psychological trauma suffered as a child, such as severe emotional, physical, or sexual abuse; a significant early loss, such as the loss of a parent; and neglect.
- **Environmental stressors:** Certain stressors such as a death or divorce, a dysfunctional family life, changing jobs or schools, and substance abuse can trigger a disorder in a person who may be at risk for developing a mental illness.

Types of mental illness

Mental illnesses are of different types and degrees of severity. Some of the major types are depression, anxiety,

schizophrenia, bipolar mood disorder, personality disorders, trauma and eating disorders. The most common mental illnesses are anxiety and depressive disorders. While everyone experiences strong feelings of tension, anxiety, or sadness at times, a mental illness is present when these feelings become so disturbing and overwhelming that people have great difficulty coping with day-to-day activities, such as work, enjoying leisure time, and maintaining relationships. At their most extreme, people with a depressive disorder may not be able to get out of bed or care for themselves physically. People with certain types of anxiety disorder may not be able to leave the house, or may have compulsive rituals to help them alleviate their fears.

Less common are mental illnesses that may involve psychosis. These include schizophrenia and bipolar mood disorder. People experiencing an acute episode of psychosis lose touch with reality and perceive their world differently from what is considered normal. Their ability to make sense of thoughts, feelings, and the world around them is seriously affected.

Intellectual disability vs mental illness

Confusion about the difference between mental illness and intellectual disability is common in the justice system. Some people with intellectual disability may also experience mental illness but the two conditions are very different.

What are the Differences between Intellectual Disability and Mental Illness?

Intellectual disability

An intellectual disability means that a person has problems with learning, understanding, processing information and problem solving. There may also be difficulties with communication, social skills and general living skills. Intellectual disability is usually present from birth and will be evident before adulthood. It is a permanent condition, not an

illness or disease. Intellectual disability cannot be cured or treated with medication. With the right support, people with intellectual disabilities can learn enough life skills to cope and be involved in their community. This where Camphill comes in, providing a secure and active community in which people with intellectual disability can reach their full potential.

- Thoughts are limited by cognitive ability and understanding.
- Is lifelong and will not dissipate.
- Onset occurs before 18 years of age.
- Medication cannot restore cognitive ability.
- Assessed by a psychologist.

CONCLUSION

Mental illness affects emotions, mood, perceptions and behaviour and can be suffered by people of all levels of intellectual ability. Mental illness can onset at any age (although it is unlikely to affect children before puberty). It can be a temporary condition, be experienced in cycles, or episodes may recur throughout life. Mental illness is treated with medication and psychosocial support. With the right treatment those suffering from it can manage their symptoms and live a normal, independent life. Examples of mental illness include schizophrenia, bipolar disorder and major depression.

- Disturbances in thought processes and perception. May experience hallucinations and delusions.
- May be temporary, cyclical or episodic.
- Onset can occur at any stage of life.
- Medication can be prescribed to control the symptoms.
- Diagnosed by a psychiatrist.

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Impact of Conflict on Mental Health with Special Reference to Kashmir Valley

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ABSTRACT

Conflict has a negative impact on the lives of people and the society as a whole. The emotional and psychological effect of the consequential violence is deeply felt by all, irrespective of gender, age, career and locality. In Kashmir the conflict has brought about insecurity, breakdown of social relations and families. This has led to the youth of Kashmir to switch to drugs or undertake anti-social activities. In health care and the field of public health, a lot of stress and resources have been devoted to the screening, diagnosis, and cure of mental illness than focusing on mental health. Little has been done to guard the mental health of those free of mental illness. The present paper throws light on the impact of conflict on mental health with special reference to Kashmir. The paper is a literature based on the previous studies. The concept of conflict is looked into and a reference to the impact of conflict in Kashmir has been made. It explains health, mental health, the indicators of mental health and how there is more focus on mental illness rather than mental health. Finally there is an exploration of the impact of violence in Kashmir.

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Keywords: *Mental Health, Conflict, Depression, Kashmir*

The situation in Kashmir with the insurgence since 1947 but mostly effected from 1989 things got affected. The prevailing condition from the time 1989 has not only depreciated the social setup, but the economic conditions as well (Sehgal, 2011). With the conflict in civil areas and huge deployment of armed forces, thousands have been killed, and thousands became widows and orphans, social relations have been destroyed and in addition to these people became psychologically ill, and are unable to undertake day to day functions. Family breakdown, family conflicts, unemployment, late marriages, orphanage culture, etc., raise at fast rate in these circumstances of Kashmir. Most of the educated youth of Kashmir are unemployed or underemployed. With the result most of them either switch to drugs or indulge in anti- social activities resulting damage of social and economic fiber (Dar, 2011). The emotional and psychological effect of the consequential violence is deeply felt by all, irrespective of gender, age, career and locality. The insecurity of life is usually summed up in a common utterance that once people leave house, their families are not certain if they would return.

Conflict which is sometimes also known as collective violence is defined as ‘the instrumental use of [armed] violence by people who identify themselves as members of a group – whether this group is transitory or has a more permanent identity – against another group or set of individuals, in order to achieve political, economic or social objectives’. Wars are armed conflicts with more than 1,000 battle-related deaths in any one year (Devakumar, Osrin et.al 2014). Conflict causes illness, injury and breakdown in the system that provide protective, remedial and ameliorative care. It has a deep effect on society that form a tolerant outline for the effects we describe. The mediators of loss are several, but include

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population dislocation and interruption of health services and schooling, on a background of financial decline and supply restriction. Below the fig (A) shows how these indirect effects are related with conflict and have a pervasive effect that reaches down to the following generation.

Meaning of health differs from person to person and from culture to culture. In terms of the traditional Indian view, health cannot be viewed as merely a state. It is a dynamic process of striving which ensures stability between the inner, as well as, outer factors which are continuously changing and therefore has no ideal state (Misra, 2005)

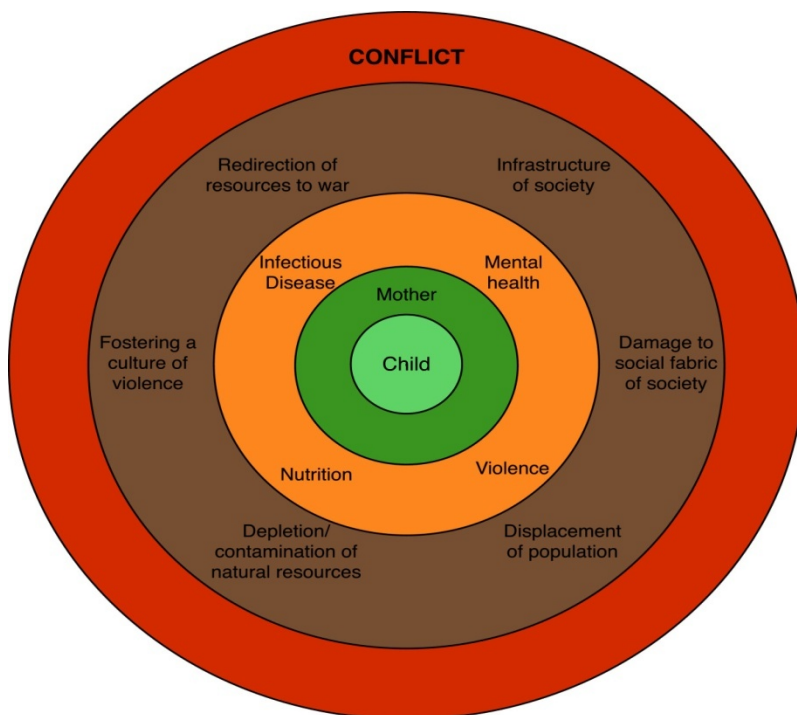


Fig. (A) Direct effects (orange) and indirect effects- as described by Levy - (brown) of conflict on mother and child.

Mental health is “a state of well- being in which the individual realizes his or her own abilities, can cope with the normal stress of life, can work productively and fruitfully, and is

able to make a contribution to his or her community” (WHO, 2001d). Mental, physical and social health, are vital strands of life that are closely intertwined and severely interdependent. Defining health as physical, mental and social wellbeing. A.V. Shah stated that mental health is "the most essential and inseparable component of health (Shah,1982).

Mental Health Indicators

In health care and the field of public health, a lot of stress and resources have been devoted to the screening, diagnosis, and cure of mental illness than focusing on mental health. Little has been done to guard the mental health of those free of mental illness. Investigators propose that there are signs of mental health, represented in three domains (Ryff, 1995, and Keyes 1998). These include the following:

➤ **Emotional well-being**

Such as perceived life gratification, happiness, exuberance, serenity.

➤ **Psychological well-being**

Such as self-acceptance, personal growth including openness to new experiences, optimism, expectation, purpose in life, control of one's environment, spirituality, self-direction, and constructive relationships.

➤ **Social well-being**

Social getting, beliefs in the potential of individuals and society as a whole, own self-worth and usefulness to society, sense of community.

Mental illness is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” (US Dept. of health and service, 1999 and Kessler et.al 2005). Depression is more likely following specific classes of experience – those involving conflict, disruption, losses and experiences of humiliation or entrapment. World Health

Organization has ranked depression as the fourth among the list of the most urgent health problems worldwide and has predicted it to become number two in terms of disease burden by 2020 overriding diabetes, cancer, arthritis etc. (WHO 1996). Evidence has shown that mental disorders, especially depressive disorders, are powerfully related to the occurrence, successful treatment, and course of many chronic diseases plus diabetes, cancer, cardiovascular disease, asthma, and obesity (Chapman D.P 2005) and many risk behaviors for chronic disease; such as, physical inoperativeness, smoking, excessive drinking, and insomnia.

The impact of conflict on mental health in Kashmir.

The conflict situation since 1989 in J&K has brought unprecedented suffering to the people. It has affected every aspect of a common Kashmiri's life. Thousands of families have lost their sole bread earners. Children and women of the Kashmir valley have gone through trauma over the period of seventeen years. The conflict situation has left behind a track of sadness, and depression. The minds of Kashmir's are permanently scarred. One of the biggest consequences of this conflict is the impact on the mental health of people in Kashmir. In any conflict situation, people tend to develop a simplistic view of things - it's good or bad, black or white & look for simple solutions. "The impact stage occurs when disaster strikes (e.g., bombs explode) brining with death, injury and destruction. The type of events includes loss, life threat Displacement torture and indirect effects like unemployment and poverty and so on. Home / communities have an important containing function as it provides a certain framework, boundary & secure base for all its members 'During conflict when homes & communities are shattered, people experience a lack of this containing function in a most acute way. This creates a sense of disruption of the secure base to all those affected." Once the conflict leads to violence, the fallout can be

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unforeseen in its extent and magnitude. In 1989, the psychiatric hospital at Srinagar saw 1700 patients, which rose to 35, 000 in 1998 and then to about 50,000 in 2002. In 2005, the patient's number had risen to 60,000.

A survey conducted by psychiatric hospital during the 90's, reveals that during the ongoing turmoil the people firstly suffered from anxiety due to fear which later on turned into depression. (Depression is an illness that interferes with the normal functioning of life. It complicates the life of not only those who have the disorder, but those who care about them). There is a definite increase in the incidence and prevalence of mental disorders. Large scale of destruction of life and poverty has caused not merely the physical loss and deprivation; it has also resulted in deep emotional scars. The experience of trauma and the severity and persistence of certain symptoms (i.e., anxiety, depression, liquor and drug addiction, and Post Traumatic Stress Disorder - PTSD) has raised the graph of mental setback in valley thereby resulted the attack on resilience, social cohesion and social capital (Trust, reciprocity, community and civic engagement). The accompanying traumas have devastating consequences on a whole lot of people particularly those affected directly. The health impact of conflict situation cannot be seen only along the lines of absolute number of causalities and trauma-related disorders among survivors, but also on the individual and at collective levels. "The peak direct human costs of civil war are mortalities and population displacements." Since the conflict started in valley, people die every day some of the deaths are so shocking that take longer time to overcome the grief and loss. However, the psychological damage is being understood only now. The mental health problems of the people need to be addressed keeping in mind the duration of the conflict in the Kashmir. "According to the United Nations Children's Fund (UNICEF), in the path of armed conflicts in the 1990s, over two million children were killed, six

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million injured/disabled, one million orphaned and fifteen million displaced."

Over this era of time, the number of people exposed to traumatic events has significantly increased. Psychological impact and additional burden of disease, death, and disability caused by violence has put people of valley in total lost. The situation of people with mental health problems in Kashmir are facing lot of problems due to the lack of infrastructure, trained and sufficient staff and social exclusion attached to the people who suffer from mental health problems due to the conflict situation. According to a survey by 'Medical Sans Frontiers' around 1.8 million people in Kashmir, accounting for nearly 45 percent of the valley's adult population, show significant symptoms of mental distress.

Mental disorders and psychosocial consequences associated with conflicts include sleeplessness, fear, nervousness, anger, aggressiveness, depression, flashbacks, alcohol and substance abuse, suicide, and domestic and sexual violence. Following a traumatic event, a large proportion of the population may experience nightmares, anxiety, and other stress-related symptoms, although these effects usually decrease in intensity over time. For some, the hopelessness and helplessness associated with persistent insecurity, statelessness and poverty will trigger ephemeral reactions such as those mentioned above. For others, conflict experiences may lead to Post-Traumatic Stress Disorder (PTSD) and chronic depression. These conditions, in turn, can lead to suicide ideation and attempts, chronic alcohol and drug abuse, interpersonal violence, and other signs of social dysfunction. Studies indicate that populations affected by conflict are not only affected by mental health problems but have associated dysfunction, which can last up to five years after the conflict. This persistent dysfunction is linked to decreased productivity, Poor nutritional, health and educational outcomes and decreased ability to participate in

development efforts. The effects of mental health and psychosocial disorders in conflict-affected populations can be an important constraint in reconstruction and development efforts (Baingana, F.2005).

Studies conducted so far clearly indicate that exposure to violence has latent implications for mental health. In areas affected by chronic strife a larger chunk of population is expected to experience mental health problems and such figures ought to apply to the people of Kashmir where high levels of psychological distress have been seen prevalent in the (Jong, Kam, Ford, Lokuge, Fromm, Galen, et al. 2008). A considerable increase in the number of people being diagnosed with acute stress reaction, depressive disorders, anxiety disorders, and post-traumatic stress disorder (Khan & Beg, 1993; Margoob, Firdosi, Banal, Khan, Malik, Sheikh, et al. 2006) where the prevalence of post-traumatic stress disorder is reported to be 15.9% (Margoob& Sheikh, 2006) which is quite alarming for the state when compared to other places.

CONCLUSION

Conflict leads to the breakdown of families, social relations, trust, economy and various other aspects of the life of the people who face it. This is true more so in the Kashmir Valley where there is a total disruption of the lives of people. This has led to unemployment or the underemployment of the educated youth where they eventually turn to drugs and anti-social activities. There is a lot of emphasis on the concept of mental illness rather than mental health and hence there is a need to bring out more focus on mental health. The conflict situation since 1989 in J&K has brought unprecedented suffering to the people and affected every aspect of their lives. Thousands of families have been broken and they face a lot of trauma. The conflict situation has led to increase in sadness, and depression. One of the biggest consequences of this conflict is the impact on

the mental health of people in Kashmir. Studies clearly indicate that people in Kashmir face high levels of psychological distress. There is a considerable increase in the number of people being diagnosed with acute stress reaction, depressive disorders, anxiety disorders, and post-traumatic stress disorder which is quite alarming compared to other places.

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Abuse against Widowhood in India

Dr. Pooja Varma^{1*}

ABSTRACT

Bereavement in all cultures is a compound crisis. It is a painful emotional shock, a sharp change in social status, often an economic catastrophe and usually an introspective challenge to the widow. She is subjected to total segregation and stigma. The various abuses in widowhood goes unreported without protective and therapeutic assistance, rather they are left to suffer in silence. The present article discusses the nature and incidence of abuse in widowhood in India and presents an overview of research findings to date. The implications for counsellors and clinicians working with abused women in India are highlighted. Avenues for intervention for removing the stigma include challenging cultural beliefs, accepting role and being resilient. Furthermore, efforts to address victimization should focus on empowering survivors, promoting healthy coping, and addressing their individual needs.

Keywords: *Widowhood, Abuse, India. Intervention, Counseling*

Widowhood is not just transition from one marital status to another after the death of the husband. Entering in to

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widowhood is more hazardous, painful and humiliating to women than to a widower because of the discrimination, ritual sanctions of the society against the widows. With the result, widows in India not only suffer with social and economic sanctions but also face many psychological consequences, loneliness and in many cases deprivation causing emotional disturbances and imbalance (Scannell, 2003; Stroebe et al., 2001; Charlton et al., 2001; Chen, 2000; *United Nations*, 2001, 2002; *Mohindra*, 2009; Mehta et al., 2006).

Full implementation of the human rights of women and girls is essential to the progress and prosperity of the world (Unicef, 2000). This paper explores the nature and incidence of widow abuse in India and summarizes the research findings to date. Factors that put widow and her children at risk are discussed. Challenges for counselors are presented for adequately addressing and handling abuse.

Overview of Widow Abuse in India:

Estimated Incidence Rates of Widow Abuse

The concept of 'abuse' is very much relative and depends on socio-economic and cultural context. India's mortality rates are found 86 per cent higher among widows than among married women in the same age vulnerable to abuse, neglect and high levels of deprivation (Chen, 1995), particularly vulnerable were 55% of widow women over 60 years since having a male guardian can be important for their safety and status within the Indian social context (Madhurima, 2008; Dong and Simon, 2008; Kim et al, 2005). The incidence of widowhood rises sharply with age. The proportion of widows is as high as 64 per cent among women aged 60 and above, and 80 per cent among women aged 70 and above (Owen, 1996, 2000). In other words, an Indian woman who survives to old age is almost certain to become a widow.

The incidence of widowhood is lower in most of the northern states than in south India (Riessman, 2000; Miller; 1981; Mohindra et al., 2012, Chen & Dreze, 1992; Ulrich, 1988; Sohini, 2015). However, there appears to be a gross under-reporting of crimes against widows in India. The older widows are being evicted and abandoned to the temple or mosque or ashrams, some of them have been abused sexually and emotionally since early childhood as child widows (Skirbekk & James, 2014; Sahoo, 2014; Ministry of Women and Child Development, 2009; Priyabadini, 2007; Reddy, 2004). This is of great concern, given the sheer number of widows in India and that 41.6 percent of widows are living in extreme poverty (United Nations, 2001, 2002, Loomba foundation, 2011).

In rural India, the condition of widows is more pathetic (Chen, 1998) and majority of them are deprived of their inheritance rights (Agarwal, 1998; *Chaudhuri, 2012*; Panda and Agarwal, 2005) and those staying with unmarried children are struggling with acute insecurity, deprivation and violence (Reddy, 2004; Anji and Velumani, 2013) with consequences ranging from exposure to serious diseases and over-work, to targeted murder, forced marriage, child marriage, children's loss of schooling, child labour, and multiple child safety risks (trafficking and street living), including child rape (Jensen, 2005; Priyabadini, 2007; Loomba foundation, 2011).

Mourning and Burial rites in Hindu religion are one of the major socio-cultural impositions which may include "ritual cleansing by sex", inauspicious accusations, (Chandra, 2011), enforced dress, appearance and behaviour, diet, mobility restrictions, social ostracism due to their low social status (Mallick, 2008) and economic insecurities (Chen, 1998, 2000; Korang-Okrah, 2007/08; Sossou, 2002) that can lead to depression and suicide (Li et al., 2001; Lee et al., 2005; Patnaik, 2007; Patel et al, 2006; Owen, 1996, 2000; Trivedi et al, 2009; Kumari, 2014). However, the status and treatment of women by

Muslims is even worse as they reportedly experience more global distress. This is consistent with the greater subjugation of widows in Muslim culture compared with Hindu culture (Saiyad et al., 2013; Sugirtharajah, 2003).

Widow Remarriage may be forbidden in the higher castes; and where permitted, may be restricted to a family member. If a widow marries away, her spouse turned out to be an elderly widower or a divorcee (Reddy, 2004; Johnson and Shymala, 2012). If she keeps her children with her, she may fear they would be ill-treated in a second marriage.

These practices constitute human rights violations and compound the physical and emotional trauma that the death of a loved one already brings. It is also important to remember that widow abuse in the Indian context is likely to be different than other countries (Sabri et al., 2016; Shear, 2010) due to patriarchy, strict cultural and religious norms, superstitions, poverty, dependency, lack of education/skill for job and lack of empathy, understanding and social support that increases vulnerability towards discrimination, exploitation, abuse, violence and so on (Niaz & Hassan, 2006; Davar, 1999; Vatuk, 1998).

The Current State of Knowledge about Widow Abuse in India

Reviewing the various potent researches of the past the researcher have made tentative conclusions about effect of widow abuse in India-many of which parallel findings from studies in the United States (Wilcox et al, 2003; Trivedi et al., 2009). First, empirical research is providing evidence that the incidence rates of widow abuse in India are much higher than have been typically acknowledged in the general society. The daughters of widows may suffer multiple deprivations, increasing their vulnerability to abuse (Ministry of Women and Child Development, 2009; United Nations, 2002).

Second, there may be variations in widow abuse across states and regions in India (Chen and Dreze, 1992; Matey, 2009). Third, middle and old aged widows are targeted for property related violence by children and considered as a burden on the family whereas young widows are subjected to physical abuse, exploitation and both remain highly vulnerable to neglect (Lamb, 1999). Further, her ability to engage in income-earning activities is restricted due to patriarchal norms and the division of labour by gender (Chen and Dreze, 1995) that exacerbate the depressive episodes, anxiety disorder symptoms after the death of a spouse (Dev, 2016; Zisook and Shuchter, 1991; Niaz and Hassan, 2006; Bansal et al, 2010; Nandi et al., 1997; Li et al., 2001; Lee et al., 2005; Umberson et al, 1992).

Fourth, the social and economic marginalization in widowhood is manifest in poor health and high mortality levels that has a strong bearing on their health and well-being (Jensen, 2005; Schuster and Butler, 1989; Thompson *et al.*, 1989; Davar, 1999). Fifth, physical abuse often goes hand in hand with other forms of abuse in the family (Choudhuri and Deb, 2015; Skirbekk and James, 2014; Kaur et al., 2015). Sixth, the prevalence of abuse in widowhood is common across all socioeconomic levels and religions. Seventh, prevention of widow abuse requires needed changes at the family, community, state, and national level, starting from individual's heart and minds that marriage does not have to complete a women or her identity, nor does widowhood or rape have to reduce her. Then adult children need to be sensitized to the problems and feelings of the old aged widows, instead of neglecting them as non living beings to prevent social exclusion (Sohini, 2015).

Eight, government organizations and NGO's need to play a larger role in intervention services and the prevention of widow abuse in India through effective welfare strategies as income support, health care, and free education and child care (UN, 2002, Unicef, 2002).

Ninth, counselling for widow victims is extremely important and has been shown to be effective in helping her children too after physical abuse or violence has been reported or discovered. Finally, there must be much greater attention regarding the secrecy of abuse in families throughout India, and these family secrets must be made taboo by all sectors of society for the protection and welfare of women community.

Thus the most significant challenge in addressing all types of abuse and crime against women arises due to gender inequality, stereotypes, superstition, poverty, illiteracy, ignorance, cultural beliefs and practices, poor service delivery in times of crises and under reporting of cases due to practice of secrecy in the family that in fact serves to protect the perpetrator and allows the cycle of abuse to continue (Baradha, 2006, Patnaik, 2007) that prevents too the victim from getting therapeutic help when needed (Priyabadini, 2007). Therefore, mental health professionals in India are indispensable part of any prevention plan, however, may be stymied in their efforts by lack of resources and cultural prejudices prevalent in the society. Therefore, cultural competence is inevitable in prevention program suitable to fit in a culture.

Challenges for the counselors during treatment process:

The findings underline the need to develop counselling techniques and infrastructure where the social support is lacking. In contrast to men, women allowed greater latitude in expressing emotional turmoil during significant loss. They are more defined by relationships which prohibit them to return to their normal functioning quickly. It is therefore recommended that women may be encouraged to equip themselves with the skill oriented education and training to meet economic uncertainties consequent to the spousal death.

The counselor or mental health professional and the survivor work in a collaborative manner both actively involved

in the survivor's healing process through empowerment in mind in order to recover and gain a sense of control. A counselor should show respect and reiterate that the being a widow was not her fault and that her emotions are normal. The society's cultural myths centred on being a widow should also be dispelled. This should be done in a nonjudgmental way, with the counselor acting as a sounding board and not providing personal opinions on the basis of their cultural, racial, religious, or socioeconomic differences. Counselors need to learn as much as possible about cultures that are different from their own, and be thinking about how differences may have an impact on the healing process and should continually offer support in trying new, positive ways of coping. Hope substantiates victims to live on (Kübler-Ross, 1969) by the hope of reunion in a future life through the teachings of impermanence, cause-and-effect, and the cycle of death and rebirth (Cheng, 2015), so that she accepts her husband's passing away, and learned to enjoy the present moment (Fawcett, 2013) with self-loving-kindness. This significant idea from the survivor dimension urges counsellors not only to non-judgementally listen to their clients but also to facilitate them to live well without the deceased (Worden, 1991). However, counselors prevent clients from mistakenly creating superstitious hope.

Another potent condition found instrumental in understanding and handling crisis and abuse pertains to providing survivors with the opportunity for reflection on, and resolution of, their reactions to the high stress of assault. When survivors share trauma in the form of the narrative, they are actively involved in the process of moving towards closure by becoming free from habitually thinking about the trauma in such a way that causes distress (Klempner, 2000).

Finally, integrating the abusive experience gradually into one's life is the last portion of trauma recovery that would help 'demystify' the experience of abuse for them and emotionally

work through the trauma. Respect for the individual's unique needs, abilities, and pace is essential. The counselor must be self-aware and reflective – to understand her own feelings about assault, her relationships, the legal system, and other areas, and to separate these personal feelings from the survivor's emotions, life, and needs.

A change in mindset of the society is required before these women get their rightful place, for which a strong will is needed in the minds of the people, and in law-governing bodies (Trivedi et al, 2009). Existing preventive and supportive interventions needs to be expanded for the victims of gender based violence. While attempts should be made to strengthen women's economic capabilities by improving women's access and control over income and assets to reduce the stigma associated with widowhood.

Widowhood with a Meaning in Life

Indian widowhood has long been associated with victimization and vulnerability, but traditional attitudes toward widowhood are changing and reflect the higher level of sensitization towards them (Mehta et al., 2006) by their enhanced formal social participation and involvement in personal networks (Utz, 2002; Bharathi et al, 2015). Women in our culture have always being portrayed as the courageous ones. Resilience is one of her greatest strength (Ryckebosch-Dayez et al., 2016; DiGiacomo et al., 2015; Koren et al., 2016) and was found much higher in older widows (Lamb, 1999; Mallick, 2008) and even the ways to recover were quite different from younger group (Chaudhary and Chadha, 2014) incorporating the component of spiritual involvement and beliefs (George, 2010; Mhaske, 2014; Kaneez, 2015; Behera and Bhardwaj, 2015). Either she goes with the swag their of ill-treatment, becomes a prey to social maladies and domestic violence or she fights for herself, her dignity and rights and ultimately leads a life of health, success and well-

being she truly deserves depends on how well she reflects back with her overlapping identities of being an abused ‘victim’, ‘widow, and a ‘mother’ within conflict contexts (Verma, 2015). Motherhood was a much more salient theme (Lamb, 2001; Bhana, 2009) in narrative analysis among the widowed mothers with higher levels of post-traumatic growth, learned optimism, proactive coping, social support, and resilience was found in comparison to divorced mothers (Dullat, 2015; Verma, 2015; Michael et al, 2003; Richardson & Balaswamy, 2001).

Progress will not be made in any plan until widows themselves are the agents of change so that they can act strong, stand tall and look everyone in the eyes rather than filled with guilt, shame and be as a sufferer for the whole part of life (Mohindra et al, 2012). Latter creates a vicious cycle of sufferings as abuse is reinforced through victim compliance and submission. Widows' associations, in addition, must be encouraged and empowered to (Hossain, 2012; Loomba Foundation, 2011) provide therapeutic support for the ones who are not able to cope with the challenges of bereavement (Matey, 2009; Ryckebosch-Dayez, 2016; Scannell, 2003) and help them to be self-dependent, broaden their level of understanding, empathy, cooperation, coping skills, knowledge and wisdom.

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Effectiveness of NLP in Dealing with Guilt Induced Anxiety, Depression and Stress: A Case Study

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ABSTRACT

This case study indicates the efficacy of NLP based intervention techniques in reducing guilt induced anxiety and depression. These techniques were used by the author for the treatment of a 24 year old female client, over a 5 weeks period. The client suffered from anxiety and depression due to guilt over her past experiences. Pre and post intervention as well as follow up evaluations were established. A significant reduction in anxiety and depression symptoms through both objective testing and subjective reporting indicated that NLP techniques are effective in treating guilt induced anxiety, depression and stress.

Keywords: *NLP, Neuro Linguistic Programming, Guilt, Anxiety, Depression*

Anxiety is an emotional state that is generated from a number of internal representations of potential future dangers. It has not only cognitive and subjective components but also

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physiological and behavioural components. In the psychiatric manual DSM-V (American Psychiatric Association, 2013) prolonged anxiety is described in terms of symptoms such as feeling restless, fatigued, keyed-up, irritable, suffering from muscular tension, and being unable to sleep or concentrate.

Depression is characterized by pervasive sad or depressed mood and/or the loss of interest or pleasure in nearly all activities. The individual must also experience at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation or suicide plans or attempts (American Psychiatric Association, 2013).

Stress is generally defined as the body's nonspecific response or reaction to demands made on it, or to disturbing events in the environment (Rosenham & Seligman, 1989). It is a process by which we perceive and cope with environmental threats and challenges (Myers, 2005). While a certain amount of stress promotes and facilitates learning, higher levels of stress may lead to significant distress in the life and functioning of an individual.

Traditionally, the different approaches used to treat anxiety, depression and stress include pharmacotherapy and psychotherapy, either alone or in combination with each other. Studies show that even when pharmacotherapy is deemed successful, relapses are more common in pharmacotherapy alone treatment as compared to when only psychotherapy or pharmacotherapy in combination with psychotherapy is used. (Yapko, 1989, 1992). However, psychotherapy is in itself a long time consuming process with most therapies requiring 15-30 sessions.

Neuro Linguistic Programming (NLP) is based on the idea that there is a connection between the neurological processes (neuro), language (linguistic), and behavioural patterns learned through experience (programming). NLP models provide the basis for a therapeutic technique for detecting and reprogramming unconscious patterns of thought and behaviour in order to alter psychological responses of the client. NLP based interventions in psychotherapy or Neuro Linguistic Psychotherapy (NLPt) is a systemic imaginative method of psychotherapy with an integrative-cognitive approach (Schuetz et al. 2001). It is a goal-orientated work with a person paying particular regard to his/her representation systems, metaphors, sub modalities and relation matrices aimed at solving their psychological problems.

NLP based techniques are gaining popularity in the field of applied psychology as well as psychotherapy. Bigley et al. (2010) used Magnetic Resonances Investigation to show that the anxiety scores 50 participants with claustrophobia significantly reduced after NLP sessions using the fast phobia cure. Wake et al. (2013) presented a reasoned and evidenced argument for the clinical effectiveness of NLP based techniques in the treatment of phobias anxiety, PTSD, depression and addictions, alongside a supported commentary of other therapeutic applications. A meta-analysis evaluating the effectiveness of NLP therapy for individuals with social/psychological problems by Zaharia et al (2015) revealed that the NLP therapy may add an overall standardized mean difference of 0.54 with a confidence interval of CI=[0.20; 0.88].

CASE REPORT

A 24 years old unmarried female presented with complaints of guilt feelings, sadness of mood, lack of concentration, feelings of worthlessness, withdrawal from social

activities, fear of punishment from God, restlessness, nightmares, sleep disturbance and crying spells. The symptoms had a gradual onset over a period of three months following her feelings of guilt over sexting over Whatsapp. She started thinking “I am a sinner,” “I am characterless,” “My mistake is unpardonable,” “What will people think when they come to know what I have done?” and “God will punish me for my sins.” The thoughts would keep ruminating in her mind. These thoughts continued to keep her in a state of guilt as well as a fear of punishment. Consequently, she started remaining restless and would often have nightmares of being punished by God. She also feared that God may even punish her by harming her family as well. She was unable to concentrate on her studies and work, started remaining aloof from family and friends and would be lost in her thoughts of guilt and fear of punishment. Her sleep and appetite had come down. She had lost 5.5 Kilograms of weight in three months. Sometimes, she would have uncontrollable crying spells. Her symptoms matched the DSM V diagnostic criteria for depression. Rorschach Inkblot Test also revealed symptoms of panic level anxiety and depression.

ASSESSMENT TOOLS AND METHODOLOGY

The client was assessed at entry to the service using a standardised assessment tool- Depression Anxiety Stress Scale 21 (DASS 21). After the establishment of treatment goals in collaboration with the client, NLP based interventions were used to achieve those goals. The interventions were carried over 5 weeks period, one session every week. After the intervention period was over, post intervention evaluations were conducted. Thereafter, a follow up evaluation after 2 weeks was done. The results of objective testing as well as subjective reporting were compared to assess the effectiveness of the NLP based interventions.

Treatment Goals

Based on the case conceptualization, the author and the client collaboratively established the following treatment goals:

1. Achieving relaxation of mind and body;
2. Releasing the fear of punishment;
3. Dealing with the fear of what people would think;
4. Releasing the feelings of guilt.

NLP Interventions Used

The author adopted an eclectic approach working with the present case rather than following a prescribed protocol. Interventions consisted of the following tools and techniques based on NLP:

Relaxation Anchoring

Anchoring involves the use of stimulus responses to alter states. Relaxation anchoring involves building resources to teach the person to relax physiologically. The author showed the client how to stop tightening muscle groups, to pay attention to the out-breath rather than the in-breath and to orient towards enjoyable internal imagery. This technique helped the client to achieve relaxation of mind as well as body. This is something she could do whenever she felt she was getting fearful or anxious.

Swish Pattern: Auditory Digital Processing

This included altering the sub modalities of the internal voice. The process involves installing a new strategy which begins with the old triggers for the unsupportive voice and has the client say a key interrupt phrase. The client reported that she got depressed by hearing an unknown voice on the left hand side, telling her that she was a sinner and that her mistake was unpardonable. The swish involved this voice fading away into the distance, as her own voice, powerful and affirming, came in

telling her more rational beliefs, like, “Mistakes happen. Nobody is perfect.” Repeating this swish several times during the session resulted in lowering the guilt she had attached to her mistake. On a scaling of 0 to 10, she was able to bring it down from 10 in the beginning to 3 at the end of the session.

Reframing

The frame that the client had been using was that of God as a punishing agency. This is what had been putting her into a constant fear of being punished by God. The author used the metaphor of a mother for helping the client in reframing the role of God. The positive intent of a mother punishing her child was elicited, which is to correct her children for their mistakes but not to harm them. And once the mistake has been accepted and corrected, no mother ever punishes her child for the past mistakes. Using the same analogy, the client was able to reframe her attribution of God. Her new frame included, “God does not punish the repentant sinners.” Reframing helped her in releasing her fear of being punished by God.

Neuro Hypnotic Repatterning

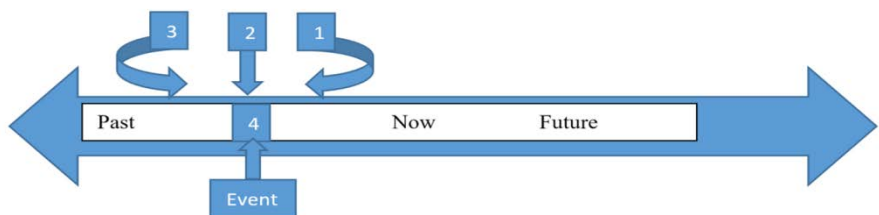
Neuro hypnotic repatterning is an exercise for reversing the anxiety (Bandler, 2008). The client got fearful and anxious at the thought of “what would people think when they get to know what I have done.” As she felt fearful and anxious, the author asked the client to notice the direction in which the anxiety spun in her body. It was in anti-clockwise direction that she found the fear spinning. She was then made to visualize it using red arrows running in anti-clockwise direction. Then she was made to imagine taking the feeling outside of her body, turning it around, changing the arrows from red to blue, and pulling it back in so the feeling spun in clockwise direction now in her body. She was made to keep spinning the feeling faster and faster in her body

till she noticed herself feeling differently. This was followed by thinking of something that made her feel really comfortable and spin this comfortable feeling as she imagined the experience going really well and working out perfectly. As she did this, she was brought to the real world, to look at what she could see in front of her in the present moment, what she could hear and all of the things in the real world that she could pay attention to. She practiced it four times during the session. With this technique, she was equipped to deal with her fear and anxiety related to what people would think of her.

Timeline Technique

This technique involves eliciting the client's timeline (Figure 1), discovering the initial sensitizing event, establishing checkpoints, calibrating positions, learning the lessons and releasing the emotion. The technique works by dealing with the unconscious rather than the conscious mind.

Figure 1: Timeline Technique



In the present case, the intervention involved asking the client to relax and draw her timeline. She was then asked to float above her timeline and move along the line into the past. When she reached the event, she should stop above it, looking down on it from above. Here, she was asked what she had learned from this event as this learning would allow her to let go of the emotions easily and effortlessly. She told she learnt the value of integrity. Thereafter she was asked to float to position 3, which was fifteen minutes before the event took place. She was then asked where the guilt was now and she found it wasn't there.

Then she was asked to float down into the event (position 4) and check on whether guilt was there or not. It wasn't there. Then coming to position 1, when she was asked if the emotion was there, it wasn't there. The emotion of guilt was replaced and the learning was saved.

DISCUSSION

Comparison of subjectively reported emotional and behavioural state during pre, post intervention and follow up evaluation:

Prior to intervention, the client had complained of guilt feelings, sadness of mood, lack of concentration, feelings of worthlessness, withdrawal from social activities, fear of punishment from God, restlessness, nightmares, sleep and appetite disturbance and crying spells. Post intervention, she reported that she felt healthy, happy, cheerful, peaceful, relaxed and optimistic. During the follow up after 2 weeks, she additionally reported increased concentration in studies as well as work. Her sleep and appetite had returned to normal. She had started enjoying her interactions with family members and her friends.

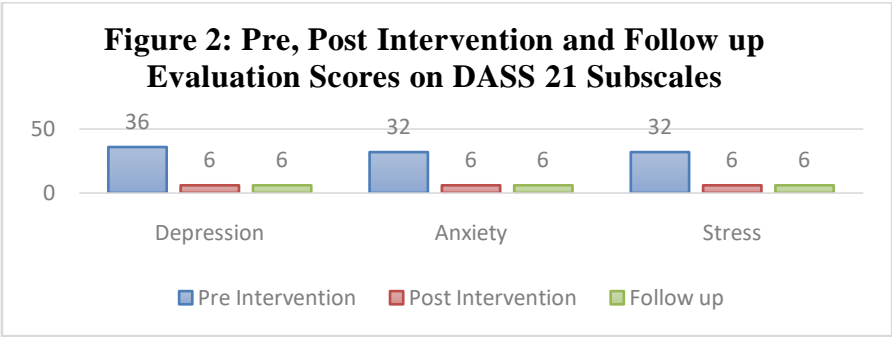
Comparison of pre, post intervention and follow up evaluation scores on DASS 21 subscales:

The pre, post intervention as well as follow up evaluation scores of the client on DASS 21 subscales have been presented in Table 1 below:

TABLE 1: Pre, Post Intervention and Follow up Evaluation Scores on DASS 21 Subscales

DASS Subscales	Pre Intervention		Post Intervention		Follow up	
	Scores	Severity	Scores	Severity	Scores	Severity
Depression	36	Extremely Severe	6	Normal	6	Normal
Anxiety	32	Extremely Severe	6	Normal	6	Normal
Stress	32	Severe	6	Normal	6	Normal

As seen in the table, the comparison between pre intervention, post intervention and follow up evaluation scores reveal that there has been a tremendous improvement in the levels of depression, anxiety as well as stress in the client. While the pre intervention scores were 36, 32 and 32 on depression, anxiety and stress subscales; the post intervention as well as follow up scores were 6, 6 and 6 on depression, anxiety and stress subscales respectively. The severity category showed a shift from extremely severe to normal in case of both depression and anxiety and from severe to normal in case of stress level. The comparison has been represented graphically in Figure 2 below:



CONCLUSION

The present findings demonstrate that the NLP based techniques offer quick and effective interventions for dealing with guilt induced anxiety, depression and stress. However, the results are the consequence of a therapeutic process and not a standardised procedure. The analysis does not consider therapist effect which is known to influence outcomes. Therefore, further studies in this area are warranted.

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Education: Personality & Mental Health

Rupali Chandola^{1*}

ABSTRACT

Aim: The aim of this study was to investigate the educational level and its effect on personality & mental health. **Material and Methods:** Study conducted on (n=60) participants of either sex (group I, n=30) was normal and another (group II, n=30) psychiatric. They were held from Nirwan neuropsychiatric hospital, Lucknow, India. GHQ-12 negative participants from the community formed the normal group age ranging between 40-45. Sentence Completion Test (SCT) administered on all the participants included in the study. **Results:** Up to 12th male had high psychiatric morbidity (83.33%) then female (40%) the difference was statistically significant at (p<.05 level). Uneducated psychiatric group (80%) very low social ambitious and confident in their personality traits.

Keywords: Education; Personality; Mental Health.

The word education is derived from Latin word educare which means 'to nourish', 'to bring up', and 'to rise'. This means, educating a child means nourishing or bringing up the

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child according to certain aims. Education is also derived from another Latin word *educere*. Education as *educere* is more acceptable as it means leading an individual out of darkness into light... Good mental health is associated with better educational and behavioural outcomes. Anxiety and depressive disorders are about twice as common in low-income and low-education groups relative to high-income and high-education groups [1,2] Data from self-reported community surveys have shown higher rates of specialty mental health services use in individuals with high education levels and no significant differences by income level [3,4,1,5]. Several recent studies have found that this association is weakened or disappear when controlling for other socio-economic variables, especially education.[6,7,8] Understanding the relation between socioeconomic status and health depends upon distinguishing these various measures and examining for independent associations with health. Consequently people with less education might feel socially trapped and helpless; contributing to the emergence of psychiatric disorders according to some psychological theories. [9] Finally less educated people might show a response bias when reporting psychological symptoms. A large body of scientific literature, mainly from western countries, shows that social disadvantage, especially lack of material possessions, lower income, and financial strain, are associated with common mental disorders [10,11,12,13, 14]. A large body of scientific literature, mainly from western countries, shows that social disadvantage, especially lack of material possessions, lower income, and financial strain, are associated with common mental disorders.[10,11,12,13,14]

Considering all the above mentioned facts and figures, this study has been taken up with an aim to study the educational level and its effect on personality & mental health amongst patients attending the psychiatry services in a hospital & normal from community.

METHODS

Sample:

The sample comprised (n=60) participants divided into two groups (group I, n=30) i.e. normal and (group II, n=30) psychiatric ranged from (40-45) were chosen at Nirwan neuropsychiatric hospital, Lucknow, India. GHQ-12 negative participants from the community formed the normal group. Sentence Completion Test was administered on all the included subjects. Mean age of normal (group I, n=30) was found to be 42.8 ± 1.44 and mean age of psychiatric (group II, n=30) was found to be 43.56 ± 1.16 . (23.33%) of the sample reported being uneducated, (21.66%) of the sample reported being up to 8th, (36.66%) of the sample reported being up to 12th and (18.33%) of the sample reported being up to post graduate.

Instruments:

Participants were required to fill in a consent form and demographic sheet before they proceed to the instruments behind. The 12-Item General Health Questionnaire [15] is the most extensively used screening instrument for common mental disorders, in addition to being a more general measure of psychiatric well-being.

Scale used in this study was sentence Completion Test (SCT) [16] it comprised of 50 incomplete sentence and the participants are instructed to complete every incomplete sentence by the first appearing thought of their mind. Objective of this test was to measure certain personality traits. An attempt has been made to measure three personality characteristics through the responses of the subjects. These traits are (1) Sociability, (2) Self Confidence, and (3) Ambitious. All the sentences are so framed that they lead to reveal the positive or negative aspect related to one of the traits.

Procedure

Participants were approached purposively and were briefed about the purpose of this study. As participants agreed to partake in this study, they were required to sign a consent letter diagnosed case of psychiatric disorder from the *hospital* and normal from the community. For psychiatric data interview conducted in the separate room associated with the ward to maintain confidentiality, (36.66%) participant's neurotic (13.33%) were psychotic and (50%) normal healthy control. Uncooperative subjects, having problem in speech and communication which can impede the interview were excluded from the study. After that, SCT with demographic detail were administered to them. Instruction for each section was written at the top part of test.

Statistical Analysis

Chi-square & Fisher exact value was used to analyze the data and evaluate the level of education and its effect on personality and mental health.

Observations & Results

The result of the present study has been given below and consecutively discussed.

Sample Characteristics

With regard to socio-demographic characteristics of the study subjects, (58.33%) were male and (41.66%) were female in both group. (70%) patients came from rural background. On the basis of religion (75%) were Hindu.

Personality traits of normal and psychiatric group regarding their score each participants on sentence completion test (SCT) were categorized in very high (90 and above), average (72-89), low (66-73) and very low (below-65) compared in (Table2).

Table 1 Comparison of mental health Status of two genders according to their education level

Level of education	Gender	Normal Group N=30	Psychiatric group N=30			X ²
			Neurotic	Psychotic	Total Psychiatric	
Uneducated N=14	Male N=10	6(60%)	3(30%)	1(10%)	4(40%)	0.28 N.S
	Female N=4	3(75%)	1(25%)	0(0%)	1(25%)	
Up to 8 th N=13	Male N=7	3(42.85%)	2(28.57%)	2(28.57%)	4(57.14%)	0.73 N.S
	Female N=6	4(66.66%)	2(33.33%)	0(0%)	2(33.33%)	
Up to 12 th N=22	Male N=12	2(16.66%)	7(58.33%)	3(25%)	10(83.33%)	4.42* p<.05
	Female N=10	6(60%)	3(30%)	1(10%)	4(40%)	
Up to post graduation N=11	Male N=6	4(66.66%)	2(33.33%)	0(0%)	2(33.33%)	0.78 N.S
	Female N=5	2(40%)	2(40%)	1(20%)	3(60%)	

*Significant at p<0.005 level

Chi square was used to compare the mental health of two gender according to their educational level, results indicated that Up to 12th male participants had high psychiatric morbidity (83.33%) then female (40%), (58.33%) suffering with neurotic problem and rest of (25%) suffering with psychotic and (60%) female found to be normal the difference is statistically significant at (p<.05 level). (Table-1)

Table-2 Level of personality traits of normal and psychiatric group according to their education level

Education level	Group	Personality Traits				Fisher's exact value
		Sociability, Self confidence & ambitiousness				
		Very high	Average	Low	Very low	
Uneducated N=14	Normal N=4	3(75%)	1(25%)	0(0%)	0(0%)	0.01*
	Psychiatric N=10	2(20%)	0(0%)	0(0%)	8(80%)	
Up to 8 th N=13	Normal N=6	5(83.33%)	1(16.66%)	0(0%)	0(0%)	0.0047*
	Psychiatric N=7	0(0%)	1(14.28%)	2(28.57%)	4(57.14%)	
Up to 12 th N=22	Normal N=12	6(50%)	1(8.33%)	4(33.33%)	1(8.33%)	0.0195*
	Psychiatric N=10	3(30%)	1(10%)	0(0%)	6(60%)	
Up to postgraduate N=11	Normal N=8	6(75%)	1(12.5%)	1(12.5%)	0(0%)	0.0485*
	Psychiatric N=3	0(0%)	0(0%)	1(33.33%)	2(66.66%)	

* Fisher exact value

Personality difference according to the educational qualification was tested using fisher exact value. Results indicated that uneducated psychiatric group (80%) very low social, ambitious and confident in their personality traits the difference was statistically significant up to 8th normal group (83.33%) very high social, confident and ambitious on their personality traits. Up to 12th 50% normal were very high social, confident and ambitious on their personality traits and up to postgraduate normal group 75% very high social, confident and ambitious on their personality traits. Significant difference was found on all educational level. (Table-2)

DISCUSSION

An attempt was made in this study to explore the possible association of education, personality & mental health. Study reported that uneducated psychiatric group (80%) very low

social, ambitious and confident in their personality traits the difference was statistically significant. Study showed that personality linked to specific labor market outcomes; it has found to educational success shown by studies on academic performance [17, 18] and school dropout probability [19]. Highly educated psychiatric population had very low social, self confident and ambitious in their personality and (75%) normal highly social, confident and ambitious. Research shows that personality traits are at least as important as cognitive skills in determining social outcomes such as criminal behavior, marital stability, and health and mortality[20,21] Up to 12th male had high psychiatric morbidity (83.33%) then female (40%) the difference is statistically significant at ($p < .05$ level). Personality traits develop mainly during childhood and adolescence, and remain relatively stable later in life[22] As a nurturing factor, education during childhood[23]. Adolescence may therefore constitute a critical determinant in an individual's long-term formation of personality.

Many research studies have been done examining education level, personality and mental health. However, because much of this research is either inconclusive or contradictory, more is needed to support or negate current research and theories.

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Conflict of Interest: None

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Evidence-Based Mental Health Counselling Model for College Students

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ABSTRACT

Professional counselling is essentially a process of interpersonal interaction, dialogue and communication based on the faith that each human being has an underlying capacity to take and implement appropriate decisions concerning his/her life. Although one of the oldest therapeutic dialogues was recorded in the Bhagavad Gita, the professional counselling which focuses on the comprehensive development of a person has not become popular in India. The increased incidence of campus violence, ragging menace, adolescent suicides, antisocial activities and complex inter and intrapersonal issues have warranted the need for counselling and social work services in the higher education sector in India. Due to the fact that the widely acknowledged counselling theories and techniques are of Euro-American origin, a strong need arises for indigenous counselling models which reflect the worldview of the Indian sub-continent for efficient intervention and effective outcome. This study uses counselling outcome reports and archival data of student-clients, together with the autoethnography study of the researcher's counselling

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process, propose a ‘Single-Session Developmental Counselling’ as an evidence-based indigenous model for counselling Indian college students.

Keywords: *Mental Health, Counselling Model, College Students*

Increased incidents of mental health issues and alarming episodes of campus violence, ragging, depression, drug abuse, suicides have raised anxiety among educationalists, social workers, mental health professionals and therapists as well as the government (Bhatia, 1993; Rakesh, 1992; Leena & Kumar, 1998; Ram & Sharma, 2005; Chopra, 2009). Although the importance of counselling services in the schools and colleges, particularly with reference to vocational and career guidance, has been emphasised in India from as early as 1938, when the Acharya Narendra Dev Committee underlined the importance, mental health related counselling services did not take its roots in the Indian educational system as seen in the West or developed countries. Although serious calls for mental health assistance have been raised by various government education bodies, they remain elusive (Bhatnagar & Gupta, 1999). The very concept of mental health wellbeing and the related concerns in the educational sector remain in its embryonic stage, which in turn accounts for the increased number of college students neglecting academic pursuits, students with unfocused academic records entering into workforce, consequently affecting various segments of the society (Janetius, Mini & Chellathurai, 2011). A major concern that arises in offering quality mental health counselling services in India is the lack of indigenous counselling and psychotherapy models. Counselling needs to integrate and incorporate the Indian worldview, cultural background and unique mindset of the people for a better outcome. Hence, some exclusive counselling models (with specific settings and stages)

that could affect the therapy process and outcome, well suited for Indian students, need to be identified to offer an effective intervention in colleges as professional counsellors.

In view of helping the Indian college students by offering quality mental health services, this research is focused on creating an evidence-based mental health counselling model that would suit well to the Indian psyche, specifically the college students. Hence, the specific objectives of the study are:

- Classify the major mental health concerns of college students
- To identify indigenous, distinctive, counselling setting for Indian college students
- Highlight the various intervention strategies and techniques preferred by the college students in the counselling process
- To create an evident-based mental health counselling model suited for the Indian student population

METHODOLOGY

This qualitative exploratory study was conducted using archival studies, evaluation reports and autoethnography. The archival data was taken from the randomly selected 680 students who received professional counselling in an autonomous college counselling centre in Tamilnadu in the academic years 2012-15. The major reasons (presenting problems) for which students came for counselling and, the various interventions and techniques used in the counselling process were methodically analysed. Autoethnography method (Tenni, Smyth, & Boucher, 2003) was used to analyse and interpret the researchers counselling process. A survey was conducted among the students who utilised counselling services to identify the various aspects of the counselling process, style and techniques used by the

researcher, and also to discover specific aspects appreciated by the student-clients.

RESULTS AND DISCUSSION

The major problems for which the students came for counselling were classified into six broad categories. Academic concerns, unwanted habits, family concerns, relationship problems, personal problems, and general consultation. The following chart shows in percentage the major concerns for which the student-clients sought counselling assistance from the college counselling centre.

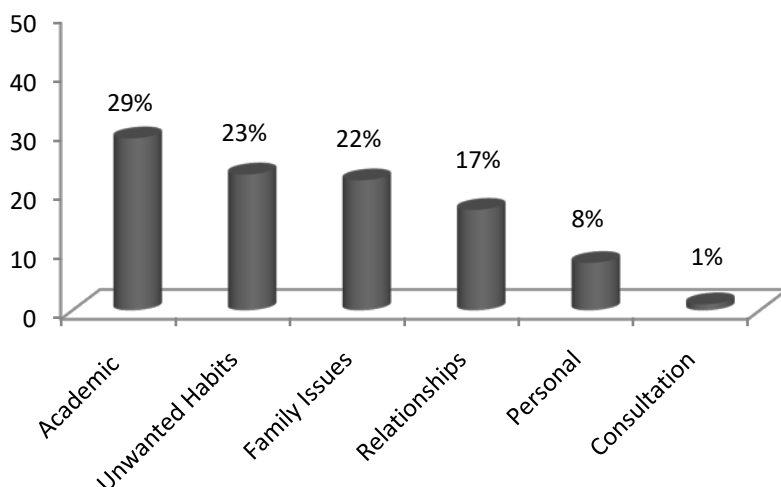


Figure 1: Showing major concerns students came for counselling

Academic problems are the top concern for which the students came for counselling, followed by unwanted habits and family issues. Unwanted habits mainly related to alcohol, drug abuse, smoking and use of pan and tobacco. Love affairs and relationship problems also are major issues among college students.

The main counselling approach used in the centre was an eclectic which is a pragmatic mixture of humanistic, cognitive, transpersonal and psychodynamic approaches in the Western counselling terms. The student concerns were dealt with a unique ecological development orientation, starting from a detailed family background moving towards independence, responsibility and goal setting.

Of the 680 student-client records studied, only 46 students came for follow-up counselling although 480 cases were asked to come for follow-up. When enquired about the lack of follow-up services, the students give the following reasons:

1.	Felt better after a single session	42%
2.	Ashamed to come again and again	7%
3.	After one session felt that they can manage the situation	34%
4.	No specific reasons	17%

The study also identifies that the various modifications, adaptations and amendments in the Western models have fetched a very high rate of success in therapy and, higher satisfaction reported by the student-clients. The following are the key changes made in the Western models of counselling structure and process for a better outcome.

a) *Duration of therapy:* Western therapy models generally prescribe the duration of a session to 50 minutes. However, the duration of a single session often extends 90 minutes to 120 minutes. The students prefer a single-session counselling as against multiple sessions.

b) *The importance of family background:* In the initial phase of counselling, a thorough analysis of family background is essential to understand the client-student and the problems. As

against the Western style, the client's problems are never understood by knowing their individual background alone.

c) *Sharing personal and other client's experiences in the process:* One of the highly recommended and appreciated features in the counselling process is the counsellor sharing his own experience or that of another student-client who has/had similar problems and issues. This creates added confidence in the student-client with the thought that s/he is not the only person having this problem.

d) *Proverbs and sayings as therapy interventions:* Greater importance is given by the student-clients when the counsellor uses proverbs and sayings of great men to stimulate change. Also, use of relevant quotes from sacred books for higher motivation and change is highly appreciated.

e) *Counsellor, a self-appointed expert:* The student-clients expect a readymade answer/solution for all their problems from the counsellor. Precautions should be taken not to give highly opinionated personal suggestions. At the same time, if the counsellor emphatically contradicts such expectations, s/he would lose the confidence and jeopardise the outcome.

f) *Termination of therapy:* Western models point out the termination of counselling as a step in which the counsellor needs to explain the cessation of therapy after a certain amount of progress is achieved. However, in the Indian context, termination is not a serious issue because once certain insights are gained or relieved from the problem, the student-client may not come for counselling even if the counsellor requests for follow-up sessions.

h) *Multicultural competence:* India is a country with various languages, religions, castes, customs and practices. There are cultural differences even among people of two different castes living in the same village or the same caste living in two different villages. This calls for every counsellor to be a multicultural therapist.

Taking into consideration the findings of the study and the identified effective aspects in the counselling process of the researcher, a *single-session mental health counselling model* (an indigenous model) is specifically drafted for Indian college students. In a single counselling session, the student-client is helped to identify the issues and certain goal-setting for future is done. The main features of this model are: through family analysis to understand and situate the problems, development concern of the stage of growth (identity creation); culture-sensitive and indigenous approach and evidence-based practice (combination of accepted best practices by the student-clients).

The three main focus areas of this counselling model are:

i) *Psycho-social development:* It is believed that all the personal, interpersonal, family and social issues of student-clients are one or other way related to the confusion arising from the adolescent/early adult developmental task (Shilpa, 2011). The problems are viewed through the medium of adolescent/early adult developmental crisis and appropriate interventions are done.

ii) *Identity creation:* The counsellor pays particular attention to the development of identity as it plays a key role in the quarter-life transition.

iii) *Academic, career and life-goal setting:* Motivation, better academic achievement and appropriate career selection are target areas throughout the sessions since many students enter into a particular stream of study owing to the pressures from their families (Janetius, Mini & Chellathurai, 2011). Together with career guidance, students are also guided for setting a life-goal as against aiming at short-term targets.

The four stages of single-session mental health counselling session are as follows: An unconditional acceptance of students from a developmental point of view is required to help them in

their problems. Also, accepting the student-client's problems in their belief system and worldview is paramount. With this basic philosophy of counselling, the four stages of this model are:

i) ***Exploring the family background:*** In the Indian scenario, the student's family background needs to be probed elaborately to understand the unique family culture and dynamics. This is because of the fact that many personal problems are interwoven with one or other family issues.

ii) ***Exploring the problem and worldview:*** In the second stage, through the medium of respecting and accepting the personal experiences of the students, the problems need to be explored. The often highlighted *empathy* in the Western models must be replaced with the *worldview of the client* (Mini, 2012) in order to understand the problem fully.

iii) ***Therapy process:*** The therapy process could be initiated once the background, belief system and the problems are explored in the worldview and family dynamics of the client. Reconciliation, with the self, others or even spiritual and religious forces could be adopted in the therapy process. Breathing exercise, imagery and visualisation exercises which are an integral part of Indian psyche could be utilised in various means and modalities. Prayer could be encouraged because many religious practices of various religious sects are similar to catharsis. If the client is not very religious, it is good to focus on some values and spirituality (doing justice, possessing rationality and free will to decide etc...).

iv) ***Goal setting and facilitating new orientation:*** In the final step, facilitate and help the client to build new patterns of thoughts, feeling and behaviours by way of visualization and auto-suggestions. Pointing great sayings from ancient wisdom, proverbs and words of eminent people would inspire the students for a quick realisation and new orientation. As the session comes to an end, assurance of help in the future with the words 'I will

pray for you...' would bring an enormous amount of positive feelings and confidence that can generate extra boost to the healing process.

CONCLUSION AND RECOMMENDATIONS

The study was conducted in a college counselling centre in view of creating an evidence-based mental health counselling model for Indian college students. The data analysed identified various elements in regard to the setting and the process of counselling; it also identified some best practices. As against the culturally insensitive Western counselling models, a more pragmatic indigenous single-session counselling that focuses on the psychosocial development of students was formulated. Since the data was collected from one counselling centre, further studies could be conducted using data from diverse settings.

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Impact of Prolonged Deprivation on Mental Health of Widows and Half-Widows in Kashmir Valley

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Zeba Ziyaiddin Khan⁴, Rakshantha, P.⁵

ABSTRACT

Objective: Mental health is not just the evasion of serious mental illness. Individual's mental health is influenced by various factors in his everyday life. Present day's mental illnesses are commonly found among people globally. Researcher's show that one out of every two adults is mentally disturbed, about 45% of adult population in Kashmir has mental distress. This paper is an endeavour to consider the impact of prolonged deprivation and widow type on mental health. **Method:** This study depends on sample of 60 subjects separated into two equivalent group's widow type (widows and half widows) and the period of deprivation (10 years and 15 years of deprivation). Mental health

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scale developed and standardized by Dr. Jagadish and Dr. A. K. Srivastava was used for data collection. For statistical analysis Mean and Two Way Analysis of Variance (ANOVA) were applied. **Findings:** The results reveal that both experimental variables (widow type and period of deprivation) have significant effect on criterion variable (Mental Health). **Conclusion:** On the basis of our findings it is concluded that half widows have poor mental health than widow, simultaneously those widows and half widows who are deprived since 15 years have poor mental health than those deprived since 10 years.

Keywords: *Prolonged Deprivation, Mental Health, Widows, Half Widows.*

Mental health is characterized as levels of mental prosperity or nonattendance of mental issue. It is a state of enthusiastic and mental flourishing in which an individual can utilize his subjective and also enthusiastic capacity, capacities for his general public and meet their regular day to day existence demands. It is a positive idea identified with the social and passionate wellbeing of individuals and communities. In common language mental health implies free from psychological and mental issues like stress, anxiety, phobias, depression and so on. Mental health is a state of flourishing in which individual comprehend his or her own capacities, abilities, can adapt to ordinary anxieties of life, can work beneficially and productively and can make contribution and commitment to his or her community.

Widow is basic term used to women whose companion is dead. In India as per the census department in 2011 around 4.6% or 5.6 crore was widows among which 40 million widows don't know about their rights while as in Kashmir since 1989 around 22806 widows are in the blink of an eye living. Bindeshwar

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Pathak, founder of Sulabh International says that in India widows are dealt with as untouchables. They confront parcel of issues in their lives even rich quantities of widows are found to begging outside religious spots, railway stations, transport stations and occupied lanes.

The term “half widow” is unique for Kashmir. It was coined by the local press in Kashmir in early 90s for those women, whose spouses vanished in the fog of violence. Half widows are those whose husbands have been vanished however not yet been proclaimed dead. In a report of APDP (Association of Parents of Disappeared Person) up to 2011 there are more than 1500 half widows in Kashmir, they are experience by different challenges in their regular life like they are not eligible for the pension which is given to widows by state social welfare division, they can't get pay given by the legislature to casualties of contention, and they have no privilege to share the property of her spouse as they have no proof of the husband's death, the law is likewise not supportive. Near it they similarly encounter the evil impacts of the steady wretchedness, trans-generational trauma, and PTSD. They have the symptoms of chronic fear, anxiety, stress etc. According to Dr Arshad Hussain, Psychiatrist from Institute of Mental Health and Neuro Sciences, Srinagar, the relatives of the vanished, especially the half-widows, frequently experience complicated grief, unresolved grief, and post traumatic stress disorder. The prolonged absence of their husbands opens these ladies to examination and policing by their general public and also dangers and control by people with noteworthy impact. The psychiatric disease hospital Srinagar shows 15% of women are suffering from stress and prolonged trauma 70 to 80 % has acute depression 16% have PTSD. Rita Pal (2003) Luis Ponte projects coordinator of MSF in Kashmir say patients visit to MSF counselling centres are 20 to 40 years old and 65 to 70 % among are women.

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In the present day world the condition of widows and half widows is excessively hopeless and miserable that expansive number of scientists approaches to compose on them and behaviour different looks into. In this study the investigator notice few of the studies which highlights the conductions of widows and half widows like, Soudiya (2012) conducted a study on women victims of armed conflict, half widows in Jammu and Kashmir. In this study the investigator highlights the problems and issues confronted by the half widows in their regular life. Menton (2007) uncovered that poverty is more likely to be seen as a dynamic construct that encompasses deprivation across material, social and cultural resources and necessities in one's life. Meraj & Arshad (2004) revealed that widows and half widows are always subjected to sexual harassment by control agencies furthermore degenerate officers ask percentage from the payment which they receive from government. Chen *et al.*, (1999) also found higher levels of traumatic grief, depressive and anxiety symptoms among widows as compared to widowers. Wani (2014) highlighted there is significant difference in mental health scores between male and female.

METHODOLOGY

Objectives:

1. To find out the effect of widow type on mental health.
2. To find out the effect of period of deprivation on mental health.
3. To find out the interaction effect between widow type and period of deprivation on mental health.

Hypotheses:

1. Widow type has significant effect on mental health.
2. Period of deprivation have significant effect on mental health.
3. There would be significant interaction effect between widow type and period of deprivation on mental health.

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Variables:

The effect of two experimental variables (Widow Type and Period of Deprivation) was study on single criterion variable that is mental health.

Sample:

In the present study 60 samples were selected through purposive sampling technique. Further all the 60 subjects were equally divided into two group's on the basis of widow type (widows and half-widows), these two groups were also equally divided in to two more subgroups according to the period of deprivation (10 and 15 years).

Measuring Tool:

Mental health scale developed and standardized by Dr. Jagadish and Dr. A. K. Srivastava was used for data collection. The scale consists of 44 items with 16 positive and 28 negative items with 4 point scale (Always, Often, Rarely and Never). Positive items are scored as 1,2,3,4 and negative are scored as 4,3,2,1 respectively. The reliability of the scale is measured by Split-half method and was found 0.73.

Procedure

The study was conducted between the month of May and June 2016 in Baramulla district of Jammu and Kashmir state 60 subjects were randomly selected. During data collection investigator meets the subjects personally and told them about the purpose of meeting. After the willingness of subject the mental health scale was handover to her and was asked to read the instructions carefully before submitting their responses. Investigator also read and helps the subject to understand the instructions and statements properly. Nearly after 20-25 minutes the scale was taken from the subject, hence the data was

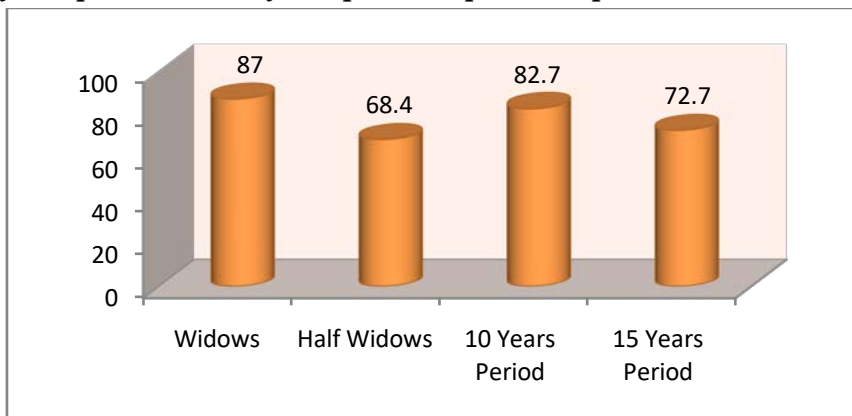
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collected. Then obtained data was carefully systematically analyzed to find the effect of experimental variables on criterion variables. Obtained data was arranged accordingly and put in the respective groups (widows, half widows, 10 years period and 15 years period of deprivation). Experimental variables (widow type and period of deprivation) was designed as A and B respectively, simultaneously two levels of widow type were designed as widows (A1) and half widows (A2) while as deprivation period was designed as 10 years period (B1) and 15 years period (B2) respectively. All obtained scores were arranged in tabular form according to their groups then 'Mean' and 'Two Way Analysis of Variance' (ANOVA) was applied to find the main as well as interaction effects.

RESULTS

The obtained results of the present study are shown in graph and tables given underneath.

Graph- 1, Showing the mean scores of widows, half widows, 10 years period and 15 years period deprivation period



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Table- 1, Showing mean of widow type

Widow type	N	Total scores	(\bar{X})
Widow	30	2610	87
Half-widow	30	2052	68.4

Table- 2, Showing mean of period of deprivation

Period of deprivation	N	Total scores	(\bar{X})
10 Years Period	30	2481	82.7
15 Years Period	30	2181	72.7

Table- 3, Summary of ANOVA

Source of variation	S.S	df	M.S	F-ratio
(A) Widow Type	5159.4	1	5159.4	28.88*
(B) Period of Deprivation	1500	1	1500	8.39*
(AB) Interactional Effect	147	1	147	0.82
Within Group Error	10003.6	56	178.63	0

*significance 0.05 level

DISCUSSION

The results of present study exhibited that both the independent variables have sway on mental health. The significant differences were found between the mean scores of widows and half widows. The mean score of widows (A1) were found 87 and half widows (A2) 68.4 respectively. Results also show significant differences between the mean scores of 10 year and 15 year of deprivation. The mean scores 10 year deprivation (B1) were found 82.7 and 15 years deprivation (B2) was found 72.7 simultaneously. Our findings proposed that widows have better mental health as contrast with half widows. Additionally subjects with 10 years period of deprivation also have better mental health than subjects with 15 years period of deprivation.

A close look at the ANOVA table indicates that obtained F- ratio of widow type [$F(56, 1) = 28.88$] was found significant at 0.05 level of significance. This leads us to conclude that widow

type is intense variable in appreciation of mental health. Subsequently our first hypothesis is partially accepted. Our findings bear a few similitudes with those of past studies like Abdallah and Ogbeide (2002) who found that there is higher rate of mental illness among the widowed than their married counterparts. While taking about the second independent variable i.e. period of deprivation the F-ratio [$F(56, 1) = 8.39$] was found significant at 0.05 level of significance, which implies that period of deprivation is also an infantile variable in mental health. This finding is likewise bolstered by the study done by Goldman *et al.*, (1995) they found that widows from 14 years had higher rates of disability than 6 years later but were not at increased risk for mortality. Thus on the basis of our findings we can say that there is significant effect of 10 and 15 years period of deprivation on mental health. Along these lines our second hypothesis is also accepted.

Interaction between widow type and period of deprivation indicate that the obtained F- ratio [$F(56, 1) = 0.82$] was found in significant at 0.05 level of significance. Thus our third hypothesis (there is significant interaction effect between widow type and period of deprivation on mental health) is rejected.

CONCLUSION

To sum up, considering the findings of the present study, we may presume that widow type and period of deprivation are the significant factors in mental health. Mental health is a serious issue in Jammu And Kashmir State, about 45% of adult population in Kashmir is mentally disturbed mostly females. Reports shows out of 1, 30,000 patients (who visited different psychiatry units associated with government medical hospital Srinagar in 2015) more than 50 % was females. As widows and half widows in Kashmir are psychologically and economical faced various problems. Government at central as well as state

level should come forward to provide platform to NGO's, social workers, psychologists, psychiatrists and mental health professionals to help this target group of society. They should provide all the basic needs (Food, Shelter and Cloths) free of cost. Government should also establish some institutions where they can learn some basic tasks like tailoring, handicrafts, computer education etc. for both educated and illiterate group. So they earn their livelihoods and live a prosperous life.

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Relationship of Alexithymia with Mindfulness among Adolescents

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ABSTRACT

Alexithymia is a trait that makes it hard to find words for thoughts and feelings. It is experienced by both children and adults. Alexithymia is a personality construct characterized by the sub-clinical inability to identify and describe emotions in the self. Whether people are trying to regulate negative emotions or experience more positive emotions, having insight and understanding of the nature, source, and maintenance of emotions is important. The main objective was to study the Relationship of alexithymia with mindfulness among adolescents girls and boys. The sample consisted of 60 Adolescents (30 boys, 30 girls). Tests used were The Mindfulness Attention Awareness Scale (MAAS) of Brown & Ryan, 2003 and Toronto Alexithymia Scale (TAS-20) Of Bagby, Parker & Taylor (1994).

Keywords: *Alexithymia, Mindfulness, Adolescents*

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Alexithymia is defined as the inability to recognize emotions and their subtleties and textures. Here are a few examples those with alexithymia experience:

- Difficulty identifying different types of feelings
- Limited understanding of what causes feelings
- Difficulty expressing feelings
- Difficulty recognizing facial cues in others
- Limited or rigid imagination
- Constricted style of thinking
- Hypersensitive to physical sensation
- Detached or tentative connection to others

Alexithymia was first mentioned as a psychological construct in 1976 and was viewed as a deficit in emotional awareness. Research suggests that approximately 8% of males and 2% of females experience alexithymia, and that it can come in mild, moderate and severe intensities. Studies also show that alexithymia has two dimensions – a cognitive dimension, where a child or adult struggles to identify, interpret and verbalize feelings (the “thinking” part of our emotional experience) and an affective dimension, where difficulties arise in reacting, expressing, feeling and imagining (the “experiencing” part of our emotional experience).

Alexithymia has long been associated to a range of psychological disorders, from autism, depression, schizophrenia, and somatoform disorders, just to name a few. It’s very challenging for those who struggle with alexithymia to cope with co-existing psychological disorders because their innate vulnerability to understanding themselves and others complicates recovery.

There is a growing interest of psychosocial research in mindfulness and its role in coping with day-to-day stressors (KabatZinn 1990), as well as a treatment for clinical populations (Baer 2003; Segal et al. 2002). However, many aspects of the

relationship between mindfulness and emotion regulation still need to be addressed (Hill and Updegraff 2012). Specifically, no study has looked at the direct associations between mindfulness, differentiation of self, and alexithymia. It is well established that poorly differentiated individuals are less flexible and adaptive under stress, since they are less able of modulating the emotional arousal stemming from psychological pressure (Skowron et al. 2004). As a result, these individuals tend to be more emotionally reactive and engage in enmeshed or emotional cutoff relationships in response to stress or overwhelming anxiety (Nichols and Schwartz 2000)

According to Ricardo and Pereira (2015) results indicate that mindfulness seems to be a construct with great therapeutic and research potential at different levels, suggesting that some aspects of mindfulness seem to promote a better self-differentiation and prevent alexithymia. The dimensions of quality of mindfulness and acceptance were mediators in the relationship between self-differentiation and alexithymia.

Mindfulness is a form of meditation that has been linked to emotional processing (Hayes et al., 2004). The word meditation actually means familiarization, and focus of meditative practices is to become more aware, familiar, and reflective of the processes and contents of one's mind (Kabat-Zinn, 2005). Mindfulness meditation and the concept of mindfulness itself can be contrasted with alexithymia to the extent that mindfulness encourages open curiosity and attentiveness to inner experiences and becoming familiar with the arising thoughts or feelings in the body. Mindfulness has also been described as a multifaceted construct that can be compared and contrasted with competencies (or lack of) such as meta cognition, emotional intelligence and alexithymia (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Bishop et al., 2004). Research suggests that some individuals struggle with competencies that facilitate the understanding and use of

emotions (Frawley & Smith, 2001; Taylor, Bagby, & Parker, 1997).

Objective

- To study the relationship of alexithymia with mindfulness among adolescents.

Hypotheses

- There will be no relationship between alexithymia and mindfulness among adolescents.

METHODOLOGY

Sample

- For the present study 60 adolescents were selected.
- The age of the boys and girls in the sample is 15-17 years.

Tool used

- The Mindfulness Attention Awareness Scale (MAAS) - The MAAS is a 15 item instrument that measures people's tendency to be mindful of moment to moment experience. Thus, the instrument focuses on the presence or absence of attention and awareness of what occurs in the present.
- The Toronto Alexithymia Scale (TAS-20) - (Bagby, Parker, & Taylor, 1994) measures three factors of alexithymia: (1) Difficulty identifying feelings (2) Difficulty describing feelings (3) Externally oriented thinking.

ANALYSIS OF DATA AND RESULTS

The analysis of data and its interpretation is presented below. The results are shown in the following tables:-

Table, Table showing r value of relationship between alexithymia and mindfulness among Adolescents

Variable	N	R	Level of significance
Alexithymia and mindfulness	60	-0.3123	Significant at .05 level

The Table Shows that the obtained r value is .312 is greater than the table value at 0.05 significant level. Hence the null hypothesis is rejected. It is thus inferred that there is significant negative relationship between alexithymia and mindfulness among adolescents.

DISCUSSION

Alexithymia is a personality dimension that involves both *cognitive deficits*, including difficulties in recognizing, describing, and distinguishing feelings from bodily sensations of emotional arousal, and *affective deficits*, including difficulties in emotionalizing and fantasizing (Bermond et al., 2007).

The table shows that the obtained r value between alexithymia and mindfulness is greater than the table value at 0.05 significant level. Hence the null hypothesis is rejected. It is thus inferred that there is significant negative relationship between the alexithymia and mindfulness. The negative correlation shows that lesser the scores better the alexithymia and higher the scores better the mindfulness.

According to Ricardo and Pereira (2015) results indicate that mindfulness seems to be a construct with great therapeutic and research potential at different levels, suggesting that some aspects of mindfulness seem to promote a better self-differentiation and prevent alexithymia. The dimensions of quality of mindfulness and acceptance were mediators in the relationship between self-differentiation and alexithymia.

According to Bowen (1976), poorly differentiated individuals with a less coherent sense of self are less able to tolerate the experience of strong affect and are unable to distinguish thoughts from feelings. It would make sense, then, that less differentiated individuals would report greater levels of alexithymia.

Poorer mindfulness abilities (namely quality of mindfulness, awareness, and acceptance) predicted greater clinical alexithymia. Differentiation of self was not a significant predictor. In fact, studies have shown that mindfulness and stress tolerance are intimately related (Farb et al. 2012; Kabat-Zinn 1990). Individuals high in alexithymia not only lack the ability to use emotions to guide their behavior, but they are also intolerant to stress, showing limited coping resources in the presence of stressful situations (Parker et al. 2001).

Baer et al. 2004, alexithymia showed significant negative correlations with mindfulness scores. The findings clearly support a partial mediating effect of mindfulness. This is the first study to show that mindfulness has a mediating effect in the relationship between self differentiations and alexithymia.

CONCLUSION

On the basis of present study it can be concluded that there is a significant negative relationship between *Alexithymia* and mindfulness. Adolescence who has greater alexithymia show less mindfulness and less alexithymia show greater mindfulness.

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The Impact of Therapeutic Technique on Grit and Locus of Control in Adolescents

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ABSTRACT

Therapeutic technique has been applied to a variety of problems. Empirical evidence supports the efficacy of therapeutic techniques in improving personality. The goal of this study was to prove the same on psychological correlates i.e. grit and locus of control. For the present study a representative sample of ten adolescents were chosen keeping in account with no prior medical history and no current psychological treatment other than the treatment involved in this study. F.I.R.E (Freedom, Internalizing, Repeating and Emotions) technique was introduced to study its significant effect after pre and posttest on grit and locus of control. The study reports the significance of therapeutic technique in improving grit and locus of control among adolescents.

Keywords: *Therapeutic Technique, Grit, Locus Of Control And Adolescents.*

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American Psychological Association (2012) has recognized the effectiveness of psychotherapy. Psychotherapy either individual, group or family is designed to provide personality change, enhance quality of life, making better choices in life, promote healthy functioning at work or school and other relationships, American group psychotherapy association (2007). Thus indicating its importance in improving overall personality characteristics. Psychotherapy is a method to help people in the treatment of their mental illnesses (NIMH). It involves tools and techniques which helps one and all to deal with their related negative thoughts, feelings and behaviors. This treatment process involves therapist with patient along with their family members. In some cases psychotherapy alone can be proved beneficial in the treatment but in other times psychotherapy can be combined with medicines for best results.

Proutand Fedewa, (2015) in the book *“Theory and practice for school and clinical setting”*, highlighted on reality therapy which focuses on helping the adolescent in assuming responsibility which in turn helps them in improving personal self-worth, identity and total self –concept. Knowing the importance of psychotherapy proving effective in improving lives of people, an attempt has been made to test its effect on psychological correlates like grit and locus of control.

“Skill is not the same thing as achievement, either. Without effort, your talent is nothing more than your unmet potential. Without effort, your skill is nothing more than what you could have done but didn’t. With effort, talent becomes skill and, at the very same time, effort makes skill productive.”- Angela Duckworth, 2016, p. 46. As the saying states clearly more than skill or talent it’s the effort that makes the talent and skill work. Grit is a part of positive psychology, an individual’s passion and a non-cognitive personality trait coupled with strong motivation to achieve the long term goals. Grit is defined as

“perseverance and passion for long-term goals”. By Duckworth, Peterson, Matthews and Kelly.2007, p.1087. It is since 2013 educators have said that grit is the single most important factor in success at school, work, business and relationships. Grit can be increased and improved by empowering individuals. Thus psychotherapy can be tested whether it proves as an effective tool to enhance grit in an individual.

Locus of control is again an important factor which works on the belief that one can control events affecting them (Morgan, King & Schopler, 1993). Those who refer to the extent to which individuals believe they can control events affecting them. People who believe that their success or failure is due to the outside influence tend to have external locus of control. Contrarily those who believe that their success or failure is due to their own work have internal locus of control. Wolinsky, Vander, Martin, Unverzagt, Willis, Marsiske, et.al. (2010) investigated the effect of cognitive training in the improvement of locus of control among older adults and found, cognitive training that focuses on reasoning and speed of processing has the ability to improve the sense of personal control. The above review is a clear indicator that locus of control can too be strengthened with cognitive training. Thus predicting the success of these psychological correlates through therapeutic technique on adolescents is the objective by this pilot study.

LITERATURE REVIEWS

Sudhir (2015) studied cognitive behavior therapy for adolescents and findings supported the effectiveness of cognitive behavior therapy for treating a wide variety of psychological problems seen in adolescents.

Dugrin, Tranah, Stahl, Moran and Asarnow (2015) investigated the effect of therapy in reducing self harm among

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adolescents and found out that psychological therapies led to 5% of reduction in self harm.

Shah, Yusooff and Jusoh (2011) studied the effectiveness of Cognitive Behavior Therapy (CBT) on self-concept among adolescents and findings revealed significant effect of CBT on self-concept.

Baskin, Slaten, Crosby, Pufahl, Schneller and Ladell (2010) reviewed the efficacy of counseling and psychotherapy in schools and supported the need of counseling and psychotherapy for youths in school

Leinchsenring and Leibing (2003) studied the effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders and found psychodynamic and cognitive behavior therapy effective treatments of personality disorders.

Siddiqui (2015) studied spiritual intelligence in relation to achievement motivation among students of professional and nonprofessional courses and found students with professional courses were more likely to possess spiritual intelligence, achievement motivation and gritter behavior as compared to nonprofessional course students.

Hochanadal and Finamore (2015) studied fixed and growth mindset in education and how grit helps students persist in the face of adversity, concluding that growth mindset is changing student's thinking, intelligence level is not a fixed number and can change, thus recommendation in teaching growth mindset and grit facilitates long-term goals and how to achieve them. A similar study by Walters. (2014) reviewed the literature on growth mindsets and observed that people with growth mindset believed that their basic abilities can continue to be developed through hard work and dedication.

Duckworth and Gross (2014) predicted self-control and grit to be related but separable determinants of success, although

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self-control and grit entail aligning actions with intentions, they operate in different ways and over different time scales.

Duckworth and Winkler (2013) studied true grit, referred gritty individuals as tortoise-like, distinguished by their propensity to maintain effort and interest over years despite failure, adversity, and plateaus in progress. Less gritty individuals are, in contrast, more easily discouraged, prone to take naps mid-course, and frequently led off track by new passions.

Duckworth, Peterson and Matthews (2007) studied personality processes and individual differences particularly grit, where grit demonstrated incremental predictive validity of success measures over and beyond IQ and conscientiousness. Thus achievement of difficult goals entails not only talent but also the sustained and focused application of talent overtime.

Bulmash (2016) studied entrepreneurial resilience with respect to locus of control and well-being of entrepreneurs and founded entrepreneurs with high internal locus of control are more resilient and report higher levels of well-being.

Shojaee and French (2014) attempted to test the relationship between mental health components and locus of control in youth which resulted into individuals having an internal tendency in their locus of control are in higher levels of mental health in comparison to individuals with external locus of control.

Kurt, Dharani and Peters (2012) studied the Impact of locus of control expectancy on level of well-being where maximum level of happiness was achieved by individuals with a balanced locus of control expectancy alternatively known as “bi-local expectancy”.

METHODOLOGY

Sample:

The sample constituted of 10 adolescents in age group of 14 to 18 years belonging to urban area (Jaipur) with middle socioeconomic status.

Inclusion Criteria:

- Age
- Urban area
- Socioeconomic status
- No medical ailment
- No other training program

Exclusion Criteria:

- Gender difference
- Education
- Cultural and religious background

Test and Tools:

Following tests has been taken into consideration for the present investigation.

Grit Scale: 12 item Grit scale developed by Duckworth, Peterson, Matthews & Kelly(2007) is comprised of 12 statements with alternatives like, Very much like me, Mostly like me, Somewhat like me, Not much like me, Not like me at all. The maximum score on this scale is found to be 5 (extremely gritty) and the lowest on this scale is 1 (not at all gritty). Person's grit score is highly predictive of achievement under challenging circumstances.

Rotter's Locus of control scale: Rotter's Locus of control scale developed by Julian Rotter in 1966 is the most widely used questionnaire to measure locus of control is a 23 item (plus six filler items). According to Rotter, locus of control may vary based on circumstances and people could trend towards

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internality or externality as a personality trait and this scale is designed to assess this more general situations. In the analysis, high score is indicative of external Locus of control and low score indicative of internal Locus of control.

Therapeutic technique: F.I.R.E (Freedom, Internalizing, Repeating, Emotions.)

In this pilot study Freedom, Internalizing, Repeating and Emotions which has been abbreviated as F.I.R.E. technique has been chosen for adolescents to study its effect on grit and locus of control. This technique has been inspired from dynamic Cognitive Behavior Therapy to help people put a halt in their consistent negative thought process and with the help of constant repetition of this technique would eventually help the person to develop Inner Positivity to sustain and continue living their life normally. In this technique positive affirmations are made which sounds logical and can be repeated with feelings to attain freedom from the negative emotions causing the disturbance and to enhance inner compassion and perseverance for their

Variables:

Independent Variable: Therapeutic technique

Dependent Variable: Grit and Locus of control

Hypothesis:

H₀: There is no significant effect of therapeutic technique on grit and locus of control in adolescents.

H₁: There is a significant effect of therapeutic technique on grit and locus of control in adolescents.

Procedure:

A group of ten adolescents (males and females) were randomly chosen for the pretest. Before introducing the test, orientation on grit and locus of control was given so that the

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group understands the use of it in their personal lives for their future success and happiness. Test of Grit and Locus of control was administered and subjects were given instructions as per the guidelines mentioned in the tests. Next day after the test administration all the ten subjects were given individual session where the score was discussed and noting down the reasons of the result obtained, importance of F.I.R.E. was explained and the ways it can help to improve grit and loc. Each subject received 30 minutes of counseling session including disclosing the pre test scores, asking the problem areas, discussing the rationale of the technique with procedure and practice of the same. This technique was scheduled to 5-7 minutes and each subject was advised to practice four times a day for 15 days with the instructions of not to take-up any other training program of relative nature . During these days student were by themselves with constant reminders. On 16th day Individual session was done whereby each subject practiced the technique four times under supervision and seventeenth day after the individual session and practice of technique for four times post test was administered followed with handing over the reports of pre and posttest comparison to the subjects on the same day.

Statistical Analysis:

To test the preset hypothesis and to evaluate the significant effect of therapeutic technique on grit and locus of control, following analysis has been made.

RESULT AND ANALYSIS

Table 1, Inferential statistics used for Grit and Locus of Control in adolescents

N=10	Pre test		Post test		t value
	Mean	Standard deviation	Mean	Standard deviation	
Grit	2.6	0.7	4.2	0.8	-4.8*
Locus of Control	11.2	3.6	6.9	2.6	3.07*

* $p < .05$

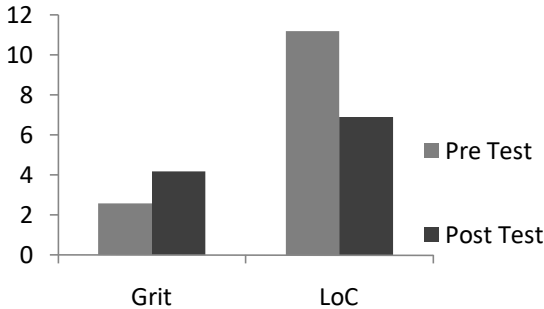


Figure1: Grit and LoC scores representing the changes in the mean and standard deviation scores from pretest to post test.

From table 1 with participants ($N = 10$) in the pretest of the variable grit ($M = 2.6$, $SD = 0.7$) scored higher in the post test ($Mean = 4.2$, $SD = 0.8$). Whereas for the second variable i.e. locus of control, participants in the pretest ($M = 11.2$, $SD = 3.6$) scored lower in the post test ($Mean = 6.9$, $SD = 2.6$). This explains clearly through graphical presentation (Figure1) of Grit and LOC representing the changes in mean and standard deviation scores from pretest to post test. The variations in the scores between pre and posttest are indicative of the effect of therapeutic technique (F.I.R.E.) on Mean and SD scores. The t-value revealed a main effect of group with $p < .05$ and the

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calculated value of grit and locus of control ($t = -4.8$, $t = 3.07$). Thus, the alternative hypothesis (H_1): There is significant difference of therapeutic technique on grit and locus of control in adolescents is proved.

DISCUSSION

The findings from the study suggest that therapeutic technique may influence participant's grit and locus of control. Technique was structured which would help the adolescents enhance their commitment and compassion for their long term goals. This process helped them to gain motivation, maintain focus for their goals and work on it till they achieve them in reality, which were evident through the changes in the statements on grit scale. Some of the statements which

Showed reduction in the level of their marking included, setting up a goal for them but changing it after sometime. In the pretest, majority of the subject gave positive response in getting obsessed with new idea or project for a short time but later losing interest in it. This changed after the intervention whereby they chose to work on new ideas till they were able to achieve the results. Adolescent is the age whereby identity formation is taking place due to which they experience many internal changes and showing greater influence with peers which sometimes compels them to follow their footsteps. Thus many of the subjects during the pretest scored high on showing difficulty in maintaining focus on projects that takes more months or years to complete, but after the intervention there was a considerable reduction to this thinking pattern leading to better focus and concentration in the chosen task or a long term goal for that matter. After the therapeutic technique subjects gained greater inner confidence with the sense of commitment in improving themselves in the areas of decision-making and working on the decision without distractions affecting them anymore. This was

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evident with the positive statements marked by subjects in considering themselves as efficient workers.

Result also showed significant improvement in enhancing internal locus of control with the help of therapeutic technique. This change was seen after the comparison of the statements marked before and after introducing the therapeutic technique. During the time of pretest subject showed belief in luck or fate influencing their lives but later came down to understanding that hard work is the real reason to success. They also felt responsible for their own actions especially during their difficult times rather than blaming it to situations or others. The idea towards political and social affairs also improved through intervention, assisting in accepting the responsibility in order to bring the change in society and also wipe out political corruption. A statement which involved willingness to accept ones mistake rather than covering up received positive acceptance by majority of the subjects. Many of the positive statements received average markings like believing in the ability to get people to do right things rather than just relying on luck. In relation to their studies or goals average response was observed in making and working towards their plans and mixed responses were found in case of considering people as good or bad.

CONCLUSION

The study concludes the effectiveness of therapeutic technique in improving the psychological correlates grit and locus of control in adolescents. Further research is needed to test its effectiveness on large samples with one or more psychological handicap.

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A study Exploring the Relationship between Subjective Happiness & Life Satisfaction

Ambika Dutta^{1*}, Faisal Aboobacker Blangayil²

ABSTRACT

Happiness and life satisfaction are the two terms which are most important for the well-being of a person. When people list the key characteristics of a good life, they are likely to include happiness and satisfaction from life. Therefore, the question what makes us happy and satisfied with our life might seem like a deeply individual inquiry. Happiness is a mental or emotional state of well-being characterized by positive or pleasant emotions ranging from contentment to intense joy. On the other hand, Life satisfaction is the way a person evaluates his or her life and how he or she feels about where it is going in the future. The present study tries to explore the relationship between Subjective Happiness and Life Satisfaction and the difference between Subjective happiness and the Life Satisfaction between the genders. For this purpose a sample of 60 students were taken and Subjective Happiness scale and Life Satisfaction scale were administered on them. Subjective Happiness scale was developed by Sonja Lyubomirsky (1997) and Life Satisfaction scale was developed by ED Diener (1984). The results showed that there is

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a significant correlation between subjective happiness and life satisfaction and among the students; male students were high on both the scales i.e. in subjective happiness and life satisfaction scale.

Keywords: *Subjective happiness, Life satisfaction*

Happiness is a mental or emotional state of well-being characterized by positive or pleasant emotions ranging from contentment to intense joy. Philosophers and religious thinkers often define happiness in terms of living a good life, or flourishing, rather than simply as an emotion. Happiness can mean many different things to many people and has number of definitions. According to Webster, Happiness gives you a feeling of pleasure and satisfaction. Positive psychology researcher Sonja Lyubomirsky elaborates, describing happiness as “the experience of joy, contentment, or positive well-being, combined with a sense that one’s life is good, meaningful, and worthwhile.” One can say that happiness is “to wanting to what I have and to have what I want” . In addition to making us feel good, studies have found that happiness actually improves other aspects of our lives. Here is an overview of some of the good stuff that research has linked to happiness.

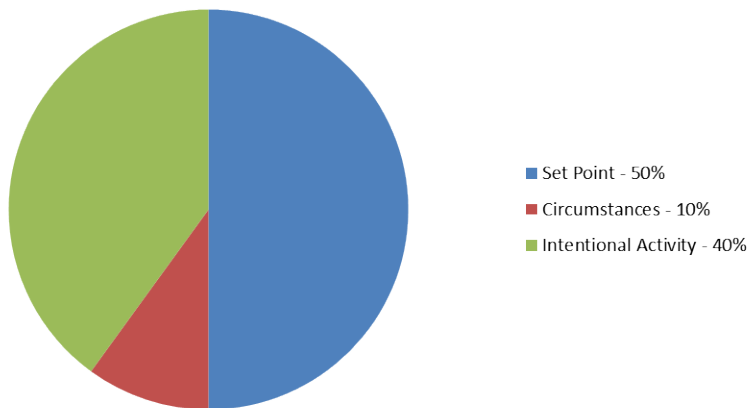
- Happiness is good for our health: Happy people are less likely to get sick, and they live longer.
- Happiness is good for our relationships: Happy people are more likely to get married and have fulfilling marriages, and they have more friends.
- Happy people make more money and are more productive at work.
- Happy people are more generous.
- Happy people cope better with stress and trauma.
- Happy people are more creative and are better able to see the big picture.

Subjective Happiness

When we talk about subjective happiness, we actually are talking about the well being of that person. Therefore, one can say that Subjective well-being (SWB) refers to how people experience the quality of their lives and includes both emotional reactions and cognitive judgments. Moreover, Psychologists have defined happiness as a combination of life satisfaction and the relative frequency of positive and negative affect. Subjective well-being can be simply defined as the individual's current evaluation of his/her happiness. According to Ed Diener, an American psychologist, subjective well-being is multidimensional and includes positive and negative emotions (e.g. the frequency, duration and intensity of joy, pleasure, happiness but also anger, guilt, fear, depression, sadness), as well as global life satisfaction, and satisfaction with different aspects of one's life (partnership, income, friends). In a 30-year longitudinal study, participants who were high in positive emotions were found to have lower rates of many health problems. Some of these illnesses/problems include lower death rates from heart disease, suicide, accidents, homicides, mental illnesses, drug dependency, and liver disease related to alcoholism. Additionally, results showed that depressed participants were more likely to have heart attacks and recurrences of heart attacks when compared to happy people.

According to Sonja Lyubomirsky the determinants of happiness are a combination of a person's genetic set-point, intentional activities and life circumstances.

Determinants of Happiness



It has also been seen that happiness enhances creativity, productivity and longevity. For instance, in a follow-back study of 180 nuns in the USA, Danner et al. (2001) found that the happiness expressed in essays that the nuns wrote as they entered the order was associated with their longevity. This was a carefully controlled study. All of the participants had similar lifestyles. They were all unmarried nuns who worked as teachers, did not smoke or drink and ate a simple balanced diet throughout their adult life. When they wrote their essays as they entered the order, they gave a biographical sketch and stated their hopes for the future, but had no idea that these essays would be used in a study of happiness and longevity. More than half a century later, the amount of positive emotions in the essays was judged by trained raters who did not know the age of the participants. Of the happiest quarter 90 per cent lived past the age of 85 compared with only 34 per cent of the least happy quarter.

Life satisfaction

Life satisfaction is the way a person evaluates his or her life and how he or she feels about where it is going in the future. It is a measure of well-being and may be assessed in terms of

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mood, satisfaction with relations with others and with achieved goals, self-concepts, and self-perceived ability to cope with daily life. It is having a favourable attitude of one's life as a whole rather than an assessment of current feelings. Life satisfaction has been measured in relation to economic standing, amount of education, experiences, and residence, as well as many other topics. Life satisfaction is affected by numerous aspects of life. These so called life domains can roughly be classified into two categories: 1) micro-social life domains (or individual living conditions) including features such as work related conditions, subjective health conditions, marital status, financial household status, and 2) macro-social life domains (or societal conditions) including aspects such as governmental performance, political democracy, welfare growth and economic equality.

Relationship between Happiness and Life Satisfaction

The question of what makes one happy and satisfied with their life might seem like a deeply individual inquiry. To measure the happiness and life satisfaction a study was done by Matthew Ericson and Tony Vinson, to look upon the key variables and their influence upon the happiness and life satisfaction of Australians. These were:

- Gender and Age: Women and men are equally likely to be happy but life satisfaction is not a constant throughout life with a dip in mid-life then resurgence as people grow older.
- Family: People who were married had a high degree of life satisfaction with 60.9% of married respondents describing themselves as highly satisfied compared to 47.2% of individuals in de facto relationships and 38.4% of respondents who were single/never married. Further to this, having a larger family, children, and possessing a high degree of trust in one's family were all factors that enhanced life satisfaction and happiness.

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- Health: Being in good health predisposes individuals to a higher degree of life satisfaction and happiness. Respondents who identified as very happy were 26 times more likely to describe their health as very good rather than poor.
- Pondering the meaning of life: People who thought about the meaning and purpose of life were less likely to be satisfied with their life than those who rarely or never engaged in such reflection.

Following is a table showing the most influential factors for an individual's level of happiness and life satisfaction

<p>The most influential factors for an individual's level of happiness are:</p> <ul style="list-style-type: none">• Their level of Health• The level of choice and control that they have over their life• Whether they are married or not• Their level of confidence in the press• Whether they trust their family or not	<p>The most influential factors for an individual's level of life satisfaction are:</p> <ul style="list-style-type: none">• The level of choice and control that they have over their life• Their level of health• Whether they are married or not• The extent to which they see themselves as a part of a local community
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Objectives

- To assess the relationship between Subjective Happiness and Life Satisfaction.
- To assess the difference between Subjective happiness and the Life Satisfaction between the gender.

METHODOLOGY

Design

The design for the present study will be of correlational bivariate data, where we will see that whether the 2 variables, i.e. Subjective Happiness and Life Satisfaction have any relationship or not

Sample

Random Sampling method was used to collect the data. For this study a sample of 60 students (30 boys and 30 girls) were taken from Manav Rachna International University. The average age of the student was 20. The sample population was the residents of NCR and Delhi.

Assessment Tool

Subjective Happiness Scale (SHS) (Lyubomirsky and Lepper, 1999) is a four item measure of global subjective happiness. Lyubomirsky and Lepper claim that SHS reflects “a broader and more molar category of wellbeing and taps into more global psychological phenomena” (1999, p. 139). In completing the SHS, respondents rate four items on different Likert scales, each ranging from 1 to 7. Participants are asked to ‘circle the point on the scale that you feel is most appropriate in describing you’. The first item asks respondents whether, in general, they consider themselves to be (1) ‘not a very happy person’ to (7) ‘a very happy person’. The second item asks if, compared to their peers, they consider themselves to be (1) ‘less happy’ to (7) “more happy”. Both the third and fourth items give descriptions and ask ‘to what extent does this characterization describe you?’ with responses ranging from ‘not at all’ to ‘a great deal’. For item three, the description is some people are generally very happy. They enjoy life regardless of what is going on, getting the most out of everything’, and item four is ‘some people are generally

A study Exploring the Relationship between Subjective Happiness & Life Satisfaction

not very happy. Although they are not depressed, they never seem as happy as they might be'.

Scores are tallied for the four items, and range from 4 to 28. An average of the four items provides a composite score for global subjective happiness; most research reports this score. The test-retest reliability of subjective happiness scale is 0.86 and the validity is 0.62.

The satisfaction and life scale (SwLS) (Diener et al., 1985) is a five item measure that assesses an individual's global judgement of life satisfaction as a whole. The SwLS measures the cognitive component of SWB, and provides an integrated judgement of how a person's life as a whole is going. In completing the SwLS, participants rate five statements (In most ways my life is close to my ideal, the conditions of my life are excellent , I am satisfied with my life , so far I have gotten the important things I want in life, if I could live my life over, I would change almost nothing) on a seven point Likert scale, ranging from (1) ' strongly disagree', to (4) ' neither agree nor disagree', to (7) ' strongly agree'. The five items are keyed in a positive direction so that responses can be added to calculate a total score, which ranges from 5-35. Pavot and Diener (2008) report that scores from 5 to 9 indicate that an individual is extremely dissatisfied with life, from 15 to 19 slightly dissatisfied with life, that a score of 20 indicates neutral life satisfaction, from 21 to 25 slight dissatisfied with life, from 26 to 30 satisfaction with life and from 31 to 35 extreme satisfaction with life. The test-retest reliability is 0.65. In validity the correlation of SwLS is excellent with Assistive Technology Device Predisposition Assessment (Spearman's $r=0.89$), Brief Symptom Inventory (Spearman's $r=0.64$) and Life Satisfaction Questionnaire (LISAT-9-11) (Spearman's $r=0.60$).

A study Exploring the Relationship between Subjective Happiness & Life Satisfaction

Procedure

A field study was done where the researcher went to 3 faculties, i.e. Faculty of Applied Sciences, Faculty of management and Faculty of Commerce and Humanities. There a rapport was made and instructions were given to them. Once they were made to understand the instructions, both the tests were given to them. After the completion of the test students were thanked for their cooperation.

RESULTS

Table 1: subjective Happiness and Life Satisfaction of total sample (N=60)

S No.	Subjective Happiness	Life Satisfaction
1	21	18
2	21	19
3	21	21
4	21	25
5	17	15
6	20	18
7	17	12
8	17	12
9	15	25
10	11	11
11	18	22
12	8	13
13	19	21
14	24	24
15	22	29
16	18	27
17	24	26
18	27	16
19	20	22
20	19	20
21	22	21
22	23	32

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S No.	Subjective Happiness	Life Satisfaction
23	17	22
24	21	25
25	18	25
26	18	27
27	28	30
28	28	29
29	17	16
30	20	20
31	21	14
32	14	28
33	21	30
34	18	21
35	19	30
36	17	27
37	21	24
38	28	21
39	24	28
40	25	31
41	18	20
42	21	21
43	24	24
44	16	23
45	11	23
46	21	30
47	26	19
48	18	19
49	22	29
50	21	32
51	20	25
52	20	25
53	27	25
54	16	17
55	19	22
56	25	19

A study Exploring the Relationship between Subjective Happiness & Life Satisfaction

S No.	Subjective Happiness	Life Satisfaction
57	21	18
58	26	26
59	25	26
60	26	21
Mean	20.38333333	22.68333333
Standard Deviation	4.210928746	5.277042272
Correlation	0.36480835	

Table I shows the Subjective Happiness and Life Satisfaction of the total sample of 60 students. From the table it can be concluded that there is a positive relationship between Subjective Happiness and Life Satisfaction, which further means that Subjective Happiness and Life Satisfaction are correlated, i.e. if the value of Subjective Happiness is increased, the value of Life Satisfaction will also increase.

Table 2.1: Subjective Happiness and Life Satisfaction in Females

S No.	Subjective Happiness	Life Satisfaction
1	21	18
2	21	19
3	21	21
4	21	25
5	17	15
6	20	18
7	17	12
8	17	12
9	15	25
10	11	11
11	22	21
12	23	32
13	17	22
14	21	25

A study Exploring the Relationship between Subjective Happiness & Life Satisfaction

S No.	Subjective Happiness	Life Satisfaction
15	18	25
16	18	27
17	28	30
18	28	29
19	17	16
20	20	20
21	18	20
22	21	21
23	24	24
24	16	23
25	11	23
26	21	30
27	26	19
28	18	19
29	22	29
30	21	32
Mean	19.7	22.1
Standard Deviation	4.009901538	5.779571634

The data shows the Subjective Happiness and Life Satisfaction of females. From the data one can conclude that they are satisfied with the life but not fully satisfied with the level of happiness in their life, as the mean for subjective happiness is 19.7 and for life satisfaction it is 22.1.

Table 2.2: Subjective Happiness and Life Satisfaction in Males

S No.	Subjective Happiness	Life Satisfaction
1	18	22
2	8	13
3	19	21
4	24	24
5	22	29
6	18	27

A study Exploring the Relationship between Subjective Happiness & Life Satisfaction

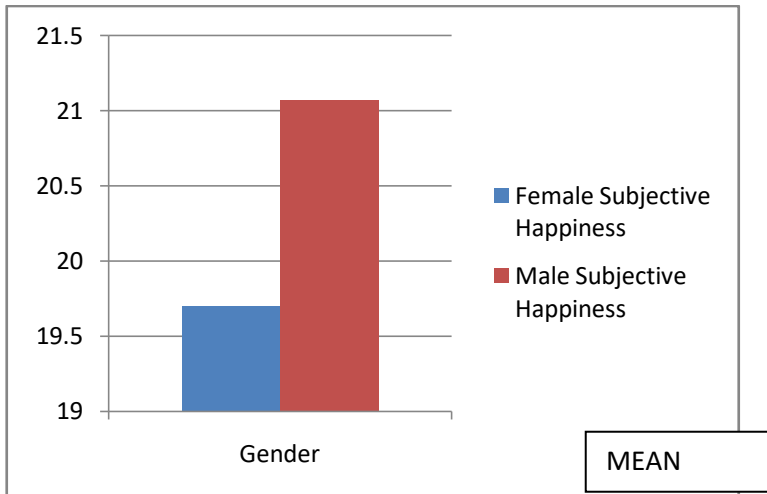
S No.	Subjective Happiness	Life Satisfaction
7	24	26
8	27	16
9	20	22
10	19	20
11	21	14
12	14	28
13	21	30
14	18	21
15	19	30
16	17	27
17	21	24
18	28	21
19	24	28
20	25	31
21	20	25
22	20	25
23	27	25
24	16	17
25	19	22
26	25	19
27	21	18
28	26	26
29	25	26
30	26	21
Mean	21.06666667	23.26666667
Standard Deviation	4.362325648	4.748381454

The data shows that male students are slightly satisfied with their level of subjective happiness and life satisfaction, as their mean value for the subjective happiness is 21.06 and for life satisfaction it is 23.26.

A study Exploring the Relationship between Subjective Happiness & Life Satisfaction

Following is the graphical representation for the Subjective happiness between genders

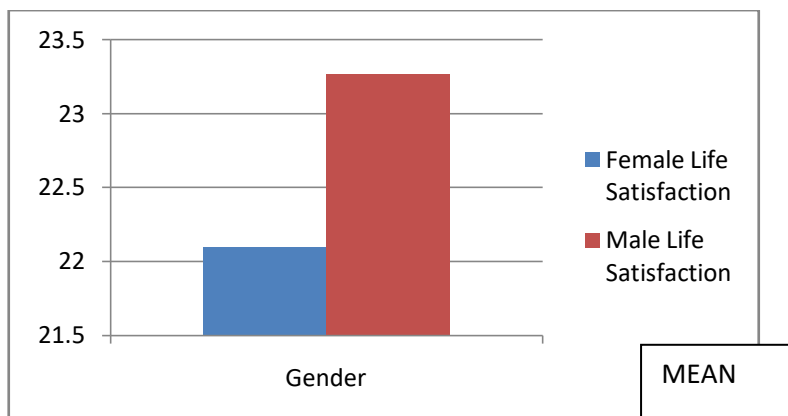
It can be concluded from the graph that male students scored more on subjective happiness as compared to female students. T score value for this scale was 1.263.



Following is the graphical representation for the Life Satisfaction between genders

It can be concluded that Life Satisfaction in male students is higher than the female students. T score value for this scale was 0.854.

A study Exploring the Relationship between Subjective Happiness & Life Satisfaction



DISCUSSION

When people list the key characteristics of a good life, they are likely to include happiness and satisfaction from life. Therefore, when we look at well-being of a person, we are looking at the level of happiness and how satisfied that person is from his/her life. Although there are other measures too which define the well-being, but happiness and the life satisfaction are the most important aspects human welfare. Happiness is a mental or emotional state of well-being characterized by positive or pleasant emotions ranging from contentment to intense joy. On the other hand, Life satisfaction is widely considered to be central aspect of human welfare. Life satisfaction is not merely a judgment about one's life. For it is widely thought to involve affirming, endorsing, appreciating or being pleased with one's life.

The first objective of the present study is to assess the relationship between Subjective Happiness and Life Satisfaction. For this purpose a sample of 60 students were taken from 3 different faculties. The results showed that the Subjective Happiness and Life Satisfaction are correlated; from this one can say that the change in the level of happiness can be seen in life satisfaction and vice versa.

A study Exploring the Relationship between Subjective Happiness & Life Satisfaction

Our second objective in the study was to see the gender difference in the level of subjective happiness and life satisfaction. Results showed that male students scored higher than the female students on both the scales. There can be many reasons for the low score of female participants, one of them is that social changes that have occurred over the past four decades have increased the opportunities available to women and a standard economic framework would suggest that these expanded opportunities for women would have increased their welfare. However, others have noted that with the expansion of opportunities have come costs and that men may have been the beneficiaries of the women's movement. In particular, many sociologists have argued that women's increased opportunities for market work have led to an increase in the total amount of work that women do. Arlie Hochschild's *The Second Shift* argued that women's movement into the paid labor force was not accompanied by a shift away from household production and they were thus now working a "second shift". Alternatively, women's lives have become more complex and their well-being now likely reflects their satisfaction with more facets of life compared with previous generations of women. For example, the reported happiness of women who are primarily homemakers might reflect their satisfaction with their home life to a greater extent than women who are in both the labour force and have a family at home. For these latter women, reported happiness may reflect aggregating over their multiple domains. While this aggregation may lead to lower reported happiness, it is difficult to know whether this reflects a truly lower hedonic state.

LIMITATIONS

The data was not collected from all the sections of the society, in present research we are only focused on the students of

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the higher education so it may be not presenting the full view of the issue.

CONCLUSION

From the study being done the conclusions drawn is that there is a positive relation between Subjective Happiness and Life Satisfaction amongst the students. Amongst these students, male students were high on both the scales, i.e. on Subjective Happiness and Life Satisfaction. Furthermore, there are several factors which are helpful to understand happiness and life satisfaction,

- One of the most important influences is social relationships.
- Another factor that influences the people is work or school, or performance in an important role such as homemaker or grandparent.
- A third factor that influences the life satisfaction of most people is personal – satisfaction with the self, religious or spiritual life, learning and growth, and leisure.

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A Comparative Study of Mental Health of Internet Addicted and Non-Addicted Adolescent Students

Mr. AtindraNath Dutta^{1*}

ABSTRACT

With the gradually increasing uses of internet in various sectors, the excessive uses of internet are also increasing. Especially in adolescents this tendency comprises like an epidemic. As a Result of excessive use of internet they become internet addicted. This internet addiction gives birth Internet Addiction Disorder (IAD). This psychological disorder affects the mental health of the person and he/she comes in a touch of anxiety, insomnia, severe depression which in turn ruined his/her personal and social life. So, from the point of importance of internet addiction and its positive relation with the bad mental health the researcher had conducted the study. For this very purpose, the researcher had chosen adolescent students from different branches of Engineering as the population of the study and 120 Engineering students of Dr. C. V. Raman University, Bilaspur, Chhattisgarh as the sample of the study. The researcher had used two tools, General Health Questionnaire-28 (GHQ-28) and Young's Internet Addiction Test (IAT) to collect the data. After analyzing the data the researcher had found that there were a great difference in the

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different dimensions and overall mental health of internet addicted and internet non-addicted students.

Keywords: *Mental health, Internet, Internet addiction, Adolescent Students.*

Since 1976 internet has been born and has become one of the most advanced technologies of today's world. The present days are called the era of 'Internet'. Humans use internet at a large content. Internet can be used in various sectors like as in learning, educating, research projects, medical science, space research, engineering, economy, defense systems, shopping, human relation, social networking, and personal interest. It is now one of our basic needs of our daily life because without it the economic criteria of a nation cannot be completed.

Due to the excessive use of internet, the users suffer from problems of trauma and mental problems. There are behavioural changes in them. Especially in adolescent school or college going students are mainly affected by it. This is called Internet Addiction Disorder (IAD). The students who suffer from this kind of addiction can have signs and symptoms of those who are addicted to alcohol, gambling, drugs, or other obsessive – compulsive behaviours. A way to describe the people who suffer this kind of disorder is, for such people virtual environments are more attractive than the real world.

For a person to be adjusted in his environment, it is very important to be mentally healthy. Good mental health is obvious for a healthy people. Mental health disorder is very dangerous and responsible for many psychological diseases and for maladjustment also.

Many research studies have shown that there is a relation between internet addiction and mental health disorder which births loneliness, shyness, isolation, symptoms of depression, low

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self-confidence, anxiety, sociophobia, and having problem in education and it is growing up in Asian as well as in Indian students. New problems such as family problems, cases of divorces, crimes are also being increased due to internet addiction and these are proved by many research studies.

Many new diseases such as whatsappities, facebookities etc. are come in front of us. Excessive use of internet is the only reason behind these newly discovered diseases.

The present study is on the adolescent students to show that internet addiction has severe effects on their mental health and make them disordered.

Significance of the study -

Now the main question is why this topic is chosen for a research study and what its importance is in our real life.

We know that uses of the internet have increased dramatically over the past several years. Originally, in the early 1990's, the main users of the internet were a small group of researchers and academics mostly in the technology field, but for many people use of the internet has now become part of their daily lives. The benefits of the internet have been widely researched and include keeping in touch with friends, making vacation plans, managing finances, assisting with educational needs, etc.

However, despite the benefits due to the tremendous increase in use, speed, interactivity, and access over the past decade, a proportion of the internet user population experiences some negative consequences of excessive internet use, as well as symptoms that can mirror an addiction. In its most general form, researchers have called this phenomenon "internet addiction".

This so called internet addiction is the main reason of a non-proved disease called "Internet Addiction Disorder (IAD)" which has a very close relation with the mental health and

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behaviors of human and especially for internet users. For its importance and significance in present context the researcher has chosen this field.

So, we see that how guidance works effectively for a child to give him/her a positive direction and to make him a good human. Thus the researcher has selected the problem as “*A Comparative Study of Mental Health of Internet Addicted and Non-Addicted Adolescent Students.*”

Statement of the Problem -The problem for the present study is stated as follows:

“A Comparative Study of Mental Health of Internet Addicted and Non-Addicted Adolescent Students.”

Definitions of the Operational Terms Used -

A. Mental Health:

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community“.

B. Adolescents:

Adolescence is the age of immaturity, the time of puberty and a critical transition period of human growth and development in between childhood and adulthood in between the ages 16 to 21. Those who are passing by this age, are called adolescents.

C. Internet Addiction:

Internet addiction (IA) is a new disorder described in 1996 by the psychologist Dr. Kimberly Young. Internet addiction is a proposed but unproven disorder that involves excessive Internet use to the extent that it interferes with daily life. Excessive use may be determined by losing track of time, neglecting basic drives such as hunger and sleep, withdrawal symptoms, and negative behaviours including anger, fatigue and social isolation.

A Comparative Study of Mental Health of Internet Addicted and Non-Addicted Adolescent Students

Objectives of the study

- i. To compare the mental health of the students with or without internet addiction.
- ii. To compare the somatic symptoms of the students with or without internet addiction.
- iii. To compare the level of anxiety or insomnia of the students with and without internet addiction.
- iv. To compare the social dysfunction of the students with and without internet addiction.
- v. To compare the severe depression of the students with and without internet addiction.

Hypotheses of the study

- H₀₁** There is no significance difference in somatic symptom dimension of mental health between internet addicted and non-addicted adolescent students.
- H₀₂** There is no significance difference anxiety/insomnia dimension of mental health between internet addicted and non-addicted adolescent students.
- H₀₃** There is no significance difference in social dysfunction dimension of mental health between internet addicted and non-addicted adolescent students.
- H₀₄** There is no significance difference in severe depression dimension of mental health between internet addicted and non-addicted adolescent students.
- H₀₅** There is no significance difference in overall mental health between internet addicted and non-addicted adolescent students.

METHOD

The researcher has adopted the method of descriptive of survey type to study the mental health of adolescent students with and without internet addiction.

A Comparative Study of Mental Health of Internet Addicted and Non-Addicted Adolescent Students

Delimitations

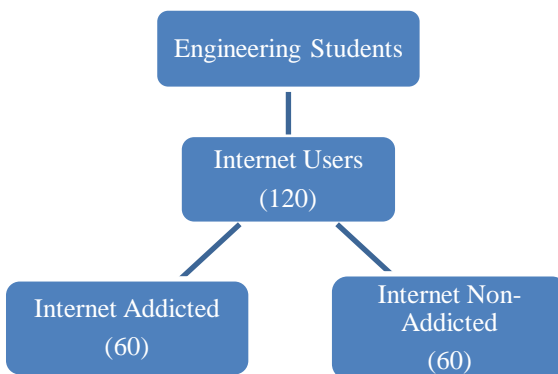
- **Area:** Dr. C. V. Raman University Campus, Kota, Bilaspur, Chhattisgarh was chosen for research purpose.
- **Levels:** - 1st year undergraduate students from Departments of Engineering were taken for this research study.

Population

Data has been collected during the month of February of academic session 2015-2016. The population for the present study are 1st year students of Engineering Departments of Dr. C.V.Raman University, Kota, Bilaspur, Chhattisgarh.

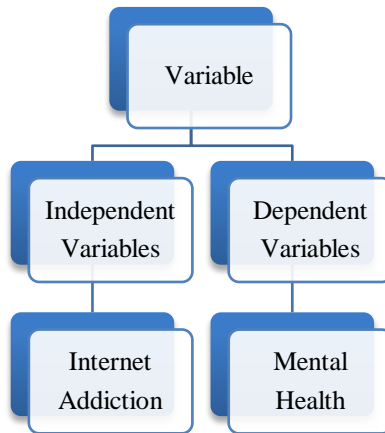
Sampling

Sampling procedure generalization on the basis of a relatively small proportion of the population is called a sample. For the purpose of present study 120 students from various engineering departments of Dr. C.V.Raman University were selected and purposive sampling technique was used.



A Comparative Study of Mental Health of Internet Addicted and Non-Addicted Adolescent Students

Variables



Independent variable: - Internet Addiction,

Dependent variable: - Mental Health.

Tool used

There are two tools which have been used in this research study which are as following:-

A. General Health Questionnaires-28 (GHQ-28):

General Health Questionnaires-28 (GHQ-28) has been developed by Goldberg and Hillier in 1979.

For evaluation of mental health, the Scaled General Health Questionnaire-28 (GHQ-28) was used. The questions of this questionnaire were analyzing the mental condition of participant in the last 1 month and include symptoms of abnormal thoughts and feeling and aspects of observable behaviour and stresses on the situation of here and now.

This questionnaire has a total of 28 items. This questionnaire consists of four sub-scales and each sub-scale consists of 7 questions as following:

- a. Questions 1 to 7 were related to physical symptoms sub-scale.
- b. 8 to 14 were related to anxiety/insomnia sub-scale.
- c. 15 to 21 were related to social dysfunction sub-scale and

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d. 22 to 28 were related to severe depression sub-scale.

There are 4 options for each item in the questionnaire as following:

- i. Not at all,
- ii. Not more than usual,
- iii. Rather more than usual,
- iv. Much more than usual.

B. Young's Internet Addiction Test (IAT)

Young's Internet Addiction Test (IAT) has been developed by Dr. Kimberley Young in 2004.

This questionnaire consists of 20 items that measure mild, moderate and severe levels of internet addiction. The 5 options for choosing are as following:

- i. Rarely,
- ii. Occasionally,
- iii. Frequently,
- iv. Often,
- v. Always.

This questionnaire had 20 items and its answering scale was 5 degree Likert which scored from 1 (rarely) to 5 (always). The score range was between 20 to 100 and higher scorers indicate more dependency to the internet.

Statistical Techniques Used -

The scores obtained were subject to statistical treatment using proper statistical techniques. For this purpose Mean, Standard Deviation, t- test, was used. The result so obtained are interpreted and discussed in the light of problem factors to make the result meaningful.

ANALYSIS AND INTERPRETATION OF DATA

H₀₁ There is no significance difference in somatic symptom dimension of mental health between internet addicted and non-addicted adolescent students.

Table No. – 01

Category .	N	Mean	SD	SED	t-test Value	df	Significance Level	H ₀₁
Internet Non-Addicted	60	2.35	0.89	0.569	16.629	118	0.05=>1.98	Rejected
Internet Addicted	60	11.81	4.31				0.01=>2.62	

a. Interpretation of the data:

It is inferred from the Table No. – 02 that the calculated ‘t’ value is 16.629, which is greater than the Table Value at 0.05 level i.e. 1.98 and at 0.01 level i.e. 2.62.

Hence hypothesis no.– 1 “There is no significance difference in somatic symptom dimension of mental health between internet addicted and non-addicted adolescent students” is rejected.

b. Result: It has been found that there is significance difference in somatic symptom dimension of mental health between internet addicted and non-addicted adolescent students.

H₀₂ There is no significance difference anxiety/insomnia dimension of mental health between internet addicted and non-addicted adolescent students.

Table No. – 02

Category .	N	Mean	SD	SE D	t-test Value	df	Significance Level	H ₀₂
Internet Non-Addicted	60	1.25	0.99	0.58	20.173	118	0.05=>1.98	Rejected
Internet Addicted	60	13	4.40				0.01=>2.62	

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a. Interpretation of the data:

It is inferred from the Table No. – 02 that the calculated ‘t’ value is 20.173, which is greater than the Table Value at 0.05 level i.e. 1.98 and at 0.01 level i.e. 2.62.

Hence hypothesis no.– 2 “There is no significance difference anxiety/insomnia dimension of mental health between internet addicted and non-addicted adolescent students” is rejected.

b. Result: It has been found that there is significance difference anxiety/insomnia dimension of mental health between internet addicted and non-addicted adolescent students.

H₀₃ There is no significance difference in social dysfunction dimension of mental health between internet addicted and non-addicted adolescent students.

Table No. – 03

Category	N	Mean	SD	SED	t-test Value	df	Significance Level	H ₀₃
Internet Non-Addicted	60	6.91	2.65	0.518	13.974	118	0.05=>1.98	Rejected
Internet Addicted	60	14.16	3.01				0.01=>2.62	

a. Interpretation of the data:

It is inferred from the Table No. – 03 that the calculated ‘t’ value is 13.974, which is greater than the Table Value at 0.05 level i.e. 1.98 and at 0.01 level i.e. 2.62.

Hence hypothesis no. – 3 “There is no significance difference in social dysfunction dimension of mental health between internet addicted and non-addicted adolescent students” is rejected.

b. Result: It has been found that there is significance difference in social dysfunction dimension of mental health between internet addicted and non-addicted adolescent students.

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H₀₄ There is no significance difference in severe depression dimension of mental health between internet addicted and non-addicted adolescent students.

Table No. – 04

Category	N	Mean	SD	SED	t-test Value	df	Significance Level	H ₀₄
Internet Non-Addicted	60	0.95	0.84	0.616	18.465	118	0.05=>1.98	Rejected
Internet Addicted	60	12.33	4.69				0.01=>2.62	

a. Interpretation of the data:

It is inferred from the Table No. – 04 that the calculated ‘t’ value is 18.465, which is greater than the Table Value at 0.05 level i.e. 1.98 and at 0.01 level i.e. 2.62.

Hence hypothesis no. – 4 “There is no significance difference in severe depression dimension of mental health between internet addicted and non-addicted adolescent students” is rejected.

b. Result: It has been found that there is significance difference in severe depression dimension of mental health between internet addicted and non-addicted adolescent students.

H₀₅ There is no significance difference in overall mental health between internet addicted and non-addicted adolescent students.

Table No. – 05

Category	N	Mean	SD	SED	t-test Value	df	Significance Level	H ₀₅
Internet Non-Addicted	60	11.43	4.10	2.014	19.63	118	0.05=>1.98	Rejected
Internet Addicted	60	50.98	15.05				0.01=>2.62	

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a. Interpretation of the data:

It is inferred from the Table No. – 05 that the calculated ‘t’ value is 19.63, which is greater than the Table Value at 0.05 level i.e. 1.98 and at 0.01 level i.e. 2.62.

Hence hypothesis no. – 5 “There is no significance difference in overall mental health between internet addicted and non-addicted adolescent students” is rejected.

b. Result: It has been found that there is significance difference in overall mental health between internet addicted and non-addicted adolescent students.

FINDINGS

- (i) There is significant difference in somatic symptom dimension of mental health between internet addicted and non-addicted adolescent students.
- (ii) There is significant difference in anxiety/insomnia dimension of mental health between internet addicted and non-addicted adolescent students.
- (iii) There is significant difference in social dysfunction dimension of mental health between internet addicted and non-addicted adolescent students.
- (iv) There is no significant difference in severe depression dimension of mental health between internet addicted and non-addicted adolescent students.
- (v) There is no significant difference in overall mental health between internet addicted and non-addicted adolescent students.

CONCLUSION

The rejections of all hypotheses and the result signifies that there is a severe difference in mental health between internet addicted and non-addicted adolescent students. The mental health of internet addicted students is severely affected by internet

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addiction disorder. They have a significant level of somatic symptoms, anxiety/insomnia, social dysfunction, severe depression than the internet non-addicted students which is very worried. So, proper caring should be needed for these internet-addicted students.

DISCUSSION

The results of the study have revealed the great danger of internet addiction. The tendency of using excessive internet among adolescents is increasing rapidly. It should be stopped. All of us from the society must try to prevent that. Some steps should be taken as- Parents should observe the activities of their children and should take care of them. They should take necessary steps to help their mentally unhealthy children and if necessary they should contact to psychologists for counseling.

Teacher can also help their students who are addicted and mentally unhealthy.

Government should take necessary steps to campaign the harmful sides of internet using into the students and a curriculum on mental health should be included into school syllabus.

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Effect of Self Esteem Enhancement on Emotional Intelligence of School Students

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ABSTRACT

Self-esteem refers to the overall subjective and emotional evaluation of the self of one's own worth and builds on the favorable experiences an individual has in one's life such as academic achievement, social competence, etc. Emotional intelligence has been described as the ability of an individual to identify, use and manage emotions in such a way as to have better experiences with others and the self. It plays a vital role in promoting social experiences that are favorable to self-esteem. The current study focused on studying the effect of self-esteem enhancement on the emotional intelligence of school students. A self-esteem enhancement package consisting of 15 sessions was developed which incorporated various activities designed to develop a realistic self and enhance self-awareness. The results showed a positive effect of self-esteem enhancement on emotional intelligence. The results obtained were discussed in view of implementation of such programs by school counselors in India to facilitate the development of a well-rounded personality of the youth passing out from the school.

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Keywords: *Self-Esteem Enhancement, Emotional Intelligence, Adolescents.*

Self-esteem is a generalized feeling about one's own self which is more or less positive in nature. Podesta (2001) describes self esteem as 'appreciating one's own worth and importance and having the character to be accountable for one self and to act responsibly towards others'. It refers to making a judgment of one's worthiness. Additionally, it is not a fleeting characteristic applicable to specific situations; it is a generalized feeling that pervades all areas of life. Self-esteem refers to liking one's self without being conceited about it, reflecting the overall appraisal of the worth that an individual places on his self.

Self-esteem can be high or low. When a person is able to accept his weaknesses and faults and simultaneously recognizes his strengths and positive qualities, the person will experience strong self-worth and high self-esteem. Low self-esteem has been found to be related to lowered success in schools (Mann, Hosman, Schaalma & de Vries, 2004). Children with low self-esteem are also less accepted by their peers (Donders & Verschueren, 2004). It has also been found to be correlated to child psychopathology including anxiety (Beck, Brown, Steer, Kuyken & Grisham, 2001), depression (Harter, 1996) and eating pathology (Muris, Meesters, V de Blom & Mayer, 2005).

Emotional intelligence refers to the ability to perceive, control and evaluate emotions. Goleman (1998) elaborates emotional intelligence to refer to 'the capacity of recognizing one's own feelings and those of others, for motivating ourselves and for managing emotions well in ourselves and in our relationships'. It can be understood as the capacity to reason about emotions and of emotions to enhance thinking. It includes the abilities to accurately perceive emotions, to access and

generate emotions so as to promote emotional and intellectual growth.

Literature suggests that emotionally intelligent persons have a higher tendency to experience better psychological well-being (Petrides & Furnham, 2006) and a lower level of emotional deficit (Salovey & Mayer, 1990) as compared to those who possess a lower level of emotional intelligence. They further reasoned that this may be so because emotionally intelligent persons have the capability to deal with their emotions more efficiently and find it easier to maintain positive mental states (Mayer & Salovey, 1995; Mayer & Salovey, 1993). Austin et al (2005) and Palmer et al (2002) also note that higher emotional intelligence is related to greater well-being. People higher in emotional intelligence have also been seen to succeed more as compared to those lower in emotional intelligence (Goleman, 1995). He further asserts that contrary to belief, IQ contributes 20% approximately only towards success in life; the rest of the credit for success is attributable to factors such as emotional intelligence, luck and social class.

Emotional intelligence and self-esteem are considered as key role players in every field of life, the practical implications of which have been examined by various researchers (Carmeli et al, 2007; Mayer, 2009). Schutte et al (2002) and Zeidner et al (2004) have reported that self-esteem is a clear indicator to develop appropriate emotional intelligence among students. Sameer (2008) has also corroborated these findings in those who were affected by the tsunami in India. Country and Chester (2005) notes that there is a good relationship between self-esteem and emotional intelligence of students. Abbas & Ul Haq (2011) also report a significant positive relationship between the two.

Self-esteem is a necessary contribution to life process and is indispensable to normal and healthy self-development and has

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a high value for survival (James, 1983). Its growth takes place in the larger context of relationship, environment related experience and attitude toward self and achievements (Gray, 2001). As the stem of self-esteem is self-awareness and is generally thought to be grounded in reality, self-esteem has been recognized as an essential contributor towards the healthy progression and normal development of the self. Various studies have demonstrated the positive effect of lifestyle enhancing activities on self-esteem. Quadrel, Fischhoff and Davis (1993) has reported the negative impact of low self-esteem on emotions and implied that low self esteem led to emotional disturbances onto violence and crime. Kail (1998) identified that children high in self-esteem judge their self more favorably and feel more positive about their self. Also, higher emotional intelligence has been typically found to be associated with positive mood as well as higher self-esteem.

Emotional intelligence and self-esteem have been shown to have a positive relationship. The beneficial effect of high self-esteem on emotional intelligence and vice versa has also been demonstrated. Keeping in view the above evidences, it was wished to assess the effect of a program designed to increase the self-esteem of an individual on emotional intelligence. Taking lead from the above mentioned studies, the following hypotheses were framed for testing:

1. There will be a significant positive difference between the pre-test and post-test means of emotional intelligence of the experimental group for boys and girls group together, for boys and for girls.
2. The pre-test and post-test emotional intelligence means of the control group will not show any significant difference.
3. There will be no significant difference between mean emotional intelligence scores for boys and girls group (pre-test and post-test).

Sample

The sample for the present study was selected from coeducational schools of Bhopal. The initial sample consisted of 658 students of 8th and 9th class - 416 boys and 242 girls. Students who had low levels of self-esteem were screened out with the help of Coopersmith Self Esteem Inventory. The final sample, thus, consisted of 155 students with low self-esteem out of which 91 were boys and 64 were girls.

Tools

1. Coopersmith Self Esteem Inventory

The inventory has been constructed by Dr. S. Coopersmith (1981). It intends to measure the self-esteem of students between the age range of 8 to 15 years. The reliability coefficient has been reported between 0.87 and 0.92 for grades 4 to 8 (Kimball, 1972). Simon and Simon (1975) correlated the school form with SRA achievement series and the coefficient of correlation was found to be 0.33 ($p < 0.01$).

2. Multifactor Emotional Intelligence Scale (Indian Version)

The scale has been constructed by Dr. V.K. Shanwal (2003, 2004). It intends to measure the emotional intelligence of adolescents covering four areas: identification of emotions, assimilation of emotions, understanding of emotions, and regulation of emotions. The scales reports high reliability and validity.

3. SE Enhancement Package (SEEP)

The SEEP comprises of 15 sessions which aimed at generating self-awareness, developing realistic self-concept and enhancing self-worth of adolescents. Audio- visual aids, affirmations, talent hunt, goal-setting, group as well as individual exercises were some of the activities included in the package. Each session was of approximately 50-55 minutes duration.

Procedure

The design of the present study was experimental pre-test post-test design with an experimental and a control group. A general ice-breaking session was conducted for the subjects who would be participating in the session. Then, the Coopersmith Self Esteem Inventory was administered on the initial sample of 658 students and the students with low levels of SE were screened out. Following which, the Multifactor Emotional Intelligence Scale was administered to find out their level of emotional intelligence. The final sample of 155 students was then divided into experimental and control group. The SE enhancement package comprising of 15 sessions (each session of approximately 50-55 minutes) was administered to the experimental group whereas the control group was not given any enhancement package. After the completion of the enhancement package with the experimental group, both the groups were again tested on the Multifactor Emotional Intelligence Scale to assess the change in the levels of emotional intelligence.

RESULTS

For the testing of the hypotheses, 't' test as applicable was applied to assess the mean differences. While testing of the first hypothesis, the pre- and post-test mean emotional intelligence scores of the experimental group were assessed.

The complete experimental group was assessed first and it was found that the mean difference in the emotional intelligence scores of the pre- and the post-test condition is statistically significant at 0.05 level of significance. The data obtained is depicted in table 1.

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Table 1 showing mean emotional intelligence scores for pre- and post-test conditions of experimental group (Combined group)

Condition	N	M	SD	SE _D	z
Pre-test	125	498.34	42.78	3.72	2.397*
Post-test	125	507.26	42.12		

$$t_{0.05} = 1.96$$

Next, the mean difference in emotional intelligence of the boys group of the experimental group was assessed. It was seen that the mean difference of the pre- and post-test mean emotional intelligence scores for the boys was significant at 0.05 level of significance. The data obtained is depicted in table 2.

Table 2 showing mean emotional intelligence scores for pre- and post-test conditions of experimental group (Boys group)

Condition	N	M	SD	SE _D	z
Pre-test	69	489.70	44.39	5.54	2.02*
Post-test	69	500.89	44.33		

$$t_{0.05}=1.96$$

For testing the third part of the hypothesis, the girls group was assessed separately. It was seen that the mean pre- and post-test emotional intelligence scores for the girls group was not statistically significant at 0.05 level of significance. The data obtained is presented in table 3.

Table 3 showing mean emotional intelligence scores for pre- and post-test conditions of experimental group (Girls group)

Condition	N	M	SD	SE _D	z
Pre-test	56	508.98	38.11	4.76	1.29
Post-test	56	515.11	37.77		

$$t_{0.05}=1.96$$

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Hence, the hypothesis is accepted for overall experimental group and for the boys group of the experimental group. However, it is not accepted for the girls group in gender specific evaluation of the efficacy of the intervention program on emotional intelligence.

For the testing of the second hypothesis, the mean pre- and post-test emotional intelligence scores of the control group were also subjected to 't' test and it was seen that there was statistically no significant difference at 0.05 level of significance in the pre- and post-test conditions for the control group. The second hypothesis, thus, is accepted indicating no statistically significant difference in the control group in the assessment of the pre- and post-test conditions. The data obtained is presented in table 4.

Table 4 showing mean emotional intelligence scores for pre- and post-test conditions of control group

Condition	N	M	SD	SE _D	Z
Pre-test	30	500.4	34.66	7.75	1.17
Post-test	30	491.37	51.83		

$t_{0.05}=1.96$

The third hypothesis would also be tested in two parts i.e. difference in the mean emotional intelligence score of boys and girls of the experimental group in the pre-test conditions and difference in the mean emotional intelligence score of boys and girls of the experimental group in the post-test conditions. It was seen that there is a significant difference in the mean emotional intelligence scores of the boys and girls of the experimental group in the pre-test condition with girls exhibiting higher emotional intelligence as compared to the boys. Hence, the hypothesis is rejected for the pre-test condition, however is

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accepted for the post-test condition. The data obtained is depicted in table 5.

Table 5 showing mean emotional intelligence scores of pre-test condition for boys and girls (experimental group)

Condition	N	M	SD	SE _D	z
Girls	56	508.98	38.11	7.38	2.61**
Boys	69	489.70	44.39		

$t_{0.01}=2.58$

For the second part of the hypothesis which seeks to assess the difference in the mean emotional intelligence scores of boys and girls of experimental group in the post-test condition. It was seen that though the girls still scored higher than the boys in emotional intelligence, the difference in the post-test condition was not statistically significant (at 0.05 level of significance). The data obtained is depicted in table 6.

Table 6 showing mean emotional intelligence scores of post-test condition for boys and girls (experimental group)

Condition	N	M	SD	SE _D	z
Girls	56	515.11	37.77	7.35	1.94
Boys	69	500.89	44.33		

$t_{0.05}=1.96$

DISCUSSION

The study aimed at discovering the efficacy of a self-esteem enhancement program on the levels of emotional intelligence of school students. The hypothesis were tested with the help of t-test and the testing of pre- and post-test mean emotional intelligence scores of the experimental group brought to light that there is a significant difference in the two conditions with the post-test mean score being significantly higher than the

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pre-test condition. As mentioned previously, self-esteem and emotional intelligence are correlated with each other and, hence, an increase in the self-esteem should demonstrate a corresponding increase in the emotional intelligence.

The boys group shows a significant increase in their level of emotional intelligence, but the girls do not. Perusing the means of the total groups of the experimental group, it can be observed that the girls group started with a higher baseline of emotional intelligence ($M=508.98$) as compared to the boys ($M=489.7$). The post-test mean for the girls ($M=515.11$) is also higher than that of the boys ($M=500.89$). However, when the means of the boys and the girls group are compared, it was observed that there is a significant difference in the emotional intelligence scores of the boys and girls group in the pre-test condition but not in the post-test condition indicating that such a program can prove quite beneficial in bridging the gap in the emotional intelligence of boys and the girls.

The activities and the intervention planned were not gender specific, hence it was seen that both the genders not only benefitted by the intervention, the package was able to narrow down the difference in the emotional intelligence of the two groups which is evident in the comparison of the means of the pre- and post-test mean emotional intelligence comparison of boys and girls group (see table 5 & table 6). Though the difference in emotional intelligence of boys and girls (experimental group) in the pre-test condition is significant, the same in the post-test condition was not found significant.

The pre- and post-test scores of the control group were also found to be statistically insignificant lending support to the assertion that the self-esteem enhancement package devised was effective in enhancing the emotional intelligence of the adolescents that were a part of the experimental group.

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Self-esteem is considered to be the affective aspect of the self and refers to the general feelings of worth that one places on his self, how he feels about his own self, the pride that that one experiences due to knowledge of self and awareness of one's positive as well as negative strengths. It refers to feeling accountable for one's self as well as to act responsibly towards others (Podesta, 2001). Emotional intelligence has been defined as the ability to adaptively recognize, understand, manage and harness emotions both in self as well as others (Mayer & Salovey, 1995; Schutte et al., 1998) and to use emotion to facilitate cognitive processing (Mayer et al., 1999). Hence, emotional intelligence can be conceptualized to be part of self-esteem dealing with emotions of the individual as well as the emotions of people around.

A package devised to enhance one's knowledge of the self should include activities aimed at increasing comprehension of what one is experiencing which helps in better understanding of the self as well as that of others. The self-esteem enhancement package consisted of activities that increased self-knowledge, helped the subjects get in touch with their feelings, and learn to enhance their interpersonal relationships. Also, the activities designed were such that they enhanced self-esteem of boys as well as girls. The efficacy of the program in the increase of self-esteem was also (not reported here) and it was found that the self-esteem of the subjects increased significantly. With the increase in self-esteem, an individual becomes better at dealing with his own self and this in turn helps him interact better with others as he starts to feel more confident about his self. This increased interaction with others helps him gain insight into the emotions felt, by self as well as by others. The more he feels confident about his self in social situations; the better would be his comprehension of affect leading to enhanced emotional intelligence.

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However, no study comes without certain limitations. The size of the experimental group and control group was not kept same. When the subjects were screened out for participation in the study, it was felt that the size of the control group should be restricted to 30 so as to approach a large sample; however, the majority should be a part of the experimental group so as to ensure enhancement of self-esteem of as many subjects as possible. Further, two or more parallel intervention programs focusing on different aspects could have been devised and the efficacy of each could have been evaluated. The number of sessions in the self-esteem enhancement program could have been supplemented with sessions relating to skill enhancement such as problem solving, decision making, etc.

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Tension Type Headache and Percieved Stress Level: A Correlational Study

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ABSTRACT

Background: Tension-type headaches (TTH), together with migraines, are the most common primary headaches, affecting 80% of the general population. Stress is known to be a contributing factor to chronic tension-type headache (CTH), with research indicating that mental stress is the most commonly reported trigger and aggravating factor of a CTH episode. The study was conducted to find out the correlation between TTH and Perceived stress level among male and female students of Rewari district in Haryana. **Methods:** Perceived Stress Scale (PSS) rating and an IHS TTH Diagnostic questionnaire were used in this study. A sample of 150 students including 75 males and 75 females in the age group of 18-25 years complaining of frequent headache were taken from different colleges and universities located in Rewari district of Haryana. In the second phase, only the diagnosed cases of tension type headache participated in the study and fill the perceived stress scale questionnaire. After data collection, analysis of data using SPSS software was done which then further help in testing the

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hypothesis and extracting the result and inferences. Descriptive analysis of quantitative data expressed as mean and standard deviation. Mean and Chi square test were used for comparison of individual on quantitative parameters between groups. P value < 0.05 was considered statistically significant. **Results:** The mean age of subjects with TTH was 22.79 ± 2.14 . Value of PSS * TTH * Gender Pearson chi square is 21.77 at a significance value of .000 and is considered as significant differences exists in the relationship of PSS * TTH * Gender. Significant correlation exists in TTH and perceived stress among males and females of 18-25 years. **Conclusion:** Significant correlation exists between tension type headache and perceived stress. Subjects with very high stress score are more likely to report chronic tension type headache.

Keywords: *Tension, Headache, Percieved Stress*

Tension type headache (TTH) is the most common form of headache what many people consider a normal headache in contrast to migraine. The recent second version of the International headache society classification distinguishes between three forms of TTH primarily on basis of headache frequency: 1) in frequent episodic TTH (fewer than 12 headache days/year). 2) frequent episodic TTH (between 12 and 180 days/year). 3) chronic TTH (at least 180 days/year) (Ashina, S.; Bendtsen, L; Jensen, R., 2006). TTH is characterized by a bilateral, pressing, tightening pain of mild to moderate intensity, occurring in short episodes of variable duration (episodic forms) or continuously (chronic forms). The headache is not associated with typical migraine features such as vomiting, severe photophobia and phonophobia. In the chronic form only one of these accompanying symptoms is allowed and only mild nausea is accepted (Jensen, R., 1999). Stress is the non-specific response

of the body to any demand for change (Seyle, H., 1936). Stress is known to be a contributing factor to chronic tension-type headache (CTH), with research indicating that mental stress is the most commonly reported trigger and aggravating factor of a CTH episode (Cathcart S. et al. 2010; Olesen J. 1991). One hypothesis for the mechanism by which stress contributes to CTH is that it aggravates already increased pain sensitivity in CTH sufferers. Correlations among pain sensitivity, stress and headache activity, and evidence that both stress and pain sensitivity predict headache activity, support this central model (Cathcart, S. et al. 2008; Bottos, S. et al. 2004). Furthermore, experimentally inducing mental stress has been demonstrated to increase pain sensitivity and headache intensity in CTH sufferers.

Published estimates of prevalence of TTH vary over a wide range from 1.3% to 65% in men and 2.7% to 86% in women. Nine studies have used the widely accepted 1988 IHS criteria to assess the epidemiology of TTH, but even among these studies prevalence estimates vary widely. Prevalence increased with increasing education level in both sexes, reaching a peak in subjects with graduate education of 48.5% for men and 48.9% for women (Brian, S.S.; Walter, F. S.; David, S.; Richard, B.L., 1998).

Young subjects are more frequently affected than older subjects (Jensen, R., 1999). The female- to -male ratio of TTH is 5:4 indicating that, unlike migraine, women are affected only slightly more than men (Stovner, L; Hagen, K. et. al., 2007). Tension-type headache is more prevalent in females than in males (male:female ratio about 1:1.5), and in both sexes prevalence declines with age (Philips 1977; Abramson et al. 1980; Rasmussen et al. 1991; Pryse-Phillips et al. 1992). Any comparison of prevalence between populations must take into account age and sex differences. On average, perceived stress is higher in individuals who report chronic daily headache than in a

healthy population. Although recurrent TTH sufferers have similar physiological responses to laboratory stressors, they report a greater number of everyday stresses or daily “hassles” than do matched non-headache control subjects. Furthermore, stressful events are appraised as more stressful for recurrent TTH sufferers than for headache-free subjects. Stress is also the most frequent headache trigger with 88% of patients from the general population in urban and rural areas reporting this variable as a cause for ensuing headache. The prevalence peaks between ages 30 to 39 and decreases slightly with age. Risk factors for developing TTH were poor self- rated health, inability to relax after work, and sleeping less hours per night (Lyngberg, A.C; Rasmussen, B.K. et. al., 2005).

Headaches generally are reported to occur in relation to emotional conflict and psychosocial stress, but the cause-and-effect relationship is not clear. The triggers reported most frequently for TTH are stress (mental or physical), irregular or inappropriate meals, high intake of coffee and other caffeine containing drinks, dehydration, sleep disorders, too much or too little sleep, reduced or inappropriate physical exercise and psychologic problems, (Rasmussen, B.K.; Jensen, R. Schroll, M. et.al., 1992). The combination of non-pharmacologic and pharmacologic treatments are prescribed separately but should go hand in hand. Psychological treatment strategies have reasonable scientific support for effectiveness. Relaxation training is a self-regulation strategy that provides patients with the ability to consciously reduce muscle tension and autonomic arousal that can precipitate and result from headaches. It is most likely that cognitive changes (i.e self-efficacy) rather than reductions in muscle tension account for the improvement in TTH with EMG (electromyography) biofeedback.

Cognitive-behavioural therapy (stress management) aims to teach patients to identify thoughts and beliefs that generate

stress and aggravate headaches. The exact degree of effect of psychological treatment strategies is difficult to estimate but Cognitive behavioural therapy is as effective as tricyclics antidepressants, whereas a combination of the two treatments seemed more effective than either treatment alone. Research indicates that CBT and stress management is most effective when combined with relaxation training or biofeedback (Holroyd, K.A.; Donnell, F.J., et.al., 2001). Finally, stress has been noted to exacerbate headache symptoms; and minor everyday stressors, rather than major life events, have been tagged as a contributor to maintaining or prolonging existing headache. Thus, stress, particularly as a result of minor everyday frustrations, is an important area of investigation in relation to headache.

Most of the evidences on Tension type headache and comorbid stress disorder comes from western studies. There is very little research looking into the prevalence of this psychological disorder in patients with TTH in a developing country like India. Due to significant socio-cultural differences, it is difficult to generalize research findings from developed countries. This therefore warrants a need to undertake basic research in a developing country like India. This study is conducted with the aim to study the prevalence of tension type headache in male /female students suffering from frequent headaches. And to find out the relationship between tension type headache and perceived stress level among male/female students.

MATERIALS AND METHODS

Sample and Data Collection

A sample size of 150 students including 75 males and 75 females in the age group of 18-25 years complaining of frequent headache was taken from different colleges and universities located in Rewari district of Haryana. The primary method of data collection was self-report questionnaires. The PSS rating

and IHS TTH Diagnostic questionnaire were used in this study. The Perceived Stress Scale (PSS10) was used to measure the degree to which situations in one's life are appraised as stressful (Cohen & Williamson, 1988).

Inclusion criteria

Consented subjects of 18-25 years should report frequent headaches, should not currently receiving (or having received in the past 12 months) intervention for headache. No psychiatric or major medical condition currently or in the past 12 months, no concurrent headache or pain symptoms or diagnoses other than CTH. CTH subjects were required to not be taking or not have taken in the past three months any analgesic medication other than ≤ 1000 mg per day of acetylsalicylic acid or paracetamol. None of the subjects reported taking prophylactic medication for headache or daily analgesic use.

Tools and Techniques

IHS (International Headache Society) Headache Diagnostic Questionnaire (Fishbain, D.A. et.al., 2001) to diagnose the tension type headache. It has satisfactory reliability and validity. The International Headache Society classification of primary headaches in the International Classification of Headache Disorders (ICHD) is almost universally accepted by researchers and clinicians. It is highly unlikely that reputable journals will accept submissions for publication if the cohorts have not been selected strictly according the ICHD. Likewise, in the clinical setting the appropriate treatment is prescribed according to how the patient's headache is classified.

Perceived Stress Scale- Perceived Stress Scale (PSS) was developed by Cohen (1985). It is designed to measure the degree to which respondents found their lives "unpredictable, uncontrollable, and overloading" (Cohen & Williamson, 1988, p.

34). The scale also includes a number of direct queries about current levels of experienced stress. As a result of factor analysis, a shorter version of the PSS scale was developed (Cohen and Williamson 1988) by the authors of the original PSS. The PSS10 was derived by dropping four items from the original scale. Cronbach's alpha coefficient for the PSS10 was .78. Individual scores on the PSS can range from 0 to 40 with higher scores indicating higher perceived stress. Scores ranging from 0-13 would be considered low-stress. Scores ranging from 14-26 would be considered moderate stress. Scores ranging from 27-40 would be considered high perceived stress levels. The Perceived Stress Scale has been shown to have a high degree of reliability and validity.

Procedure

Subjects complaining frequent headaches and fulfilled the inclusion criteria of the study were asked to fill IHS Headache Diagnostic questionnaire and then assessed to diagnose the possible cases of tension type headache. In the second phase, only the diagnosed cases of tension type headache participated in the study. Those subjects then fill the perceived stress scale questionnaire. After collecting the sufficient data, the next step was the analysis of data which then further help in testing the hypothesis and extracting the result and inferences.

Statistical Analysis

The analysis of collected data included differentiating the subjects on the basis of TTH criteria into two groups based on their gender. Descriptive analysis of quantitative data expressed as mean and standard deviation. Qualitative data were expressed as percentage and absolute numbers. Mean and Chi square test were used for comparison of individual on quantitative parameters between groups. Chi- square test was used to find correlation with SPSS software. P value < 0.05 was considered statistically significant.

RESULTS*Chi-Square Tests (TABLE 1.1)*

Gender		Value	df	Asymp. Sig. (2-sided)
Male	Pearson Chi-Square	10.23	2	.006
	Likelihood Ratio	11.876	2	.003
	Linear-by-Linear Association	9.694	1	.002
	N of Valid Cases	42		
Female	Pearson Chi-Square	14.673	2	.001
	Likelihood Ratio	17.334	2	.000
	Linear-by-Linear Association	13.748	1	.000
	N of Valid Cases	60		
Total	Pearson Chi-Square	21.77	2	.000
	Likelihood Ratio	24.298	2	.000
	Linear-by-Linear Association	20.272	1	.000
	N of Valid Cases	102		

Total 150 students including 75 males and 75 females reporting frequent headaches participated in the study. All the subjects were students with different backgrounds and studying either at graduation, post-graduation, M phil. or Doctorate level. The subjects were enrolled by strictly following the inclusion criteria. The mean age of subjects with TTH was 22.79 ± 2.14 . Out of 150 headache patients, only 102 patients were diagnosed with tension type headache, in which 42 were males and 60 were females and these 102 subjects then rated on PSS. Male/female distribution was 50:50 in subjects reported frequent headache group. Male/female distribution was then left with 28: 40 in TTH group and subjects rated on PSS. The prevalence of TTH among

frequent headache sufferers was found to be 68%. Out of 102 diagnosed cases of TTH, 68 fulfill the criteria of episodic TTH and 34 are diagnosed with chronic TTH. It means 66.7% subjects are having episodic TTH and 33.3% have chronic TTH. On statistical analysis it was found that there is significant difference among males and females on TTH criteria. That is females show high prevalence of TTH as compared to males.

Above table 1.1 shows the chi square values related to table no. 5.6 of PSS * TTH * Gender Cross-tabulation keeping p value < 0.05 as significant. Value of PSS * TTH * Males Pearson chi square is 10.23 at a significance value of .006 and is considered as significant differences exists in the relationship of PSS * TTH * Males. Value of PSS * TTH * Females Pearson chi square is 14.67 at a significance value of .001 and is considered as significant differences exists in the relationship of PSS * TTH * Females. Value of PSS * TTH * Gender Pearson chi square is 21.77 at a significance value of .000 and is considered as significant differences exists in the relationship of PSS * TTH * Gender.

DISCUSSION

Chronic headache is as much as a problem in India as elsewhere in the world with a rising trend in young adults which negatively affects the quality of life of the affected person. In current scenario of increasing prevalence of headache in students, most of them have been found to practice self - medication leading to inappropriate management and sometimes analgesic overuse causing treatment refractoriness. Headache patients frequently report stress to be one of their main activators or aggravators for headache .The association between stress and TTH has been stressed by many authors. It is supposed that stress can be a predisposing factor contributing to the onset of headache disorders, that it accelerates the progression to chronic headache, provokes and exacerbates headache episodes and that

the headache experience itself can serve as a stressor. Tension-type headache (TTH) and migraine are the most common primary headache disorders, affecting up to 80% of the general population (**Rasmussen, B.K. et al. 1993**). It is revealed from the study that significant relationship exists between tension type headache and perceived stress among males and females of 18-25 age- group. It means that the way we perceive stress can be a factor that causes TTH or aggravate the condition. It is also shown that males and females with very high stress score are experiencing chronic TTH and subjects with high stress scores may have chronic or episodic TTH. And subjects with average stress scores are suffered from episodic TTH only. It shows that there would be significant relationship among the male/female subjects on both tension type headache criteria and stress level.

It is also revealed that subjects who are diagnosed with TTH of either type also have higher stress scores. Behavioral treatments (i.e. cognitive behavioral therapy, biofeedback (Andrasik, F. 2010), relaxation training) have demonstrated clinical efficacy when practiced correctly. Yoga are mentioned to improve headache as well (Campbell, J. K. et al. 2008). Behavioral treatments may be used individually or in conjunction with pharmacologic and other interventions and may augment the effectiveness of other treatments, or minimize the need for their use. Our results underline the need for stress management strategies in people with chronic headache or having a high or with very high scores.

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Essential Evil Called Mental Health: Why Is It Important

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ABSTRACT

Positive psychology and its contributions must be immensely celebrated as the young branch of psychology attempts to celebrate positive emotions. Unconditional regard, healthy joyous emotions were never accepted as an important factor in adolescent growth and development. Academicians, counsellors, psychologists and sociologists for long have been talking about healthy child rearing and upbringing but the ways to enhance the same were not looked into. With passing year, variables like gratitude, emotional affect, satisfaction with life, mental health, positive and negative regard and well being are now being put in light of adolescents upbringing and development. Counselling sessions are held and workshops delivered to teach ways of enhancing mental health and positive emotions- this is a very positive change and must truly be celebrated. Present paper delves into more reasons to talk about mental health and its essential role in today's scenario across gender, situations and emotions.

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Keywords: *Mental Health, Gender Differences, Healthy Upbringing, Satisfaction with Life, Positive Psychology*

The World Health Organisation (WHO) defines health as, "*A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (WHO, 2004). However, creating health-oriented as existing illness-oriented services has proved rather more difficult than the clarity of this declaration would suggest. Efforts to generate a science of pathology and illness have been very successful, with shared taxonomies to identify types of illness, established and validated interventions to treat and manage these identified illnesses, and clinical guidelines, quality standards available to increase efficiency and equity and provide intervention plans to handle the deficiencies. These successes later have not been mirrored by equivalent advances in applying the science of well-being and mental health within health services, until so far. A typical health worker will know a lot about treating illness and handling the pathology, and far less about promoting well-being, mental health and positive emotions, as it has never been the focus of psychology until Positive Psychology came into existence. It was then that the picture started changing for better.

It is now being considered that, mental health services can very effectively promote well-being and positive mental health and development. Well-being is becoming a central focus of international policy, *health mission, development programmes, thus concluding that it is now possible for people experience recovery from mental illness and gain emotional balance towards more positive affect and thus, positive mental health and development.*

A focus on improving social inclusion, becoming social activists who challenge stigma and discrimination, and promote societal well-being may need to become the norm rather than the exception for mental health professionals in the 21st Century.

Again WHO in 2004, declared that mental health is "*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*". A relative lack of workforce skills in promoting well-being is particularly important in mental health services, since mental disorders directly impact our personal identity and ability to maintain social roles.

This distinction between mental illness and mental health is empirically validated, with only modest correlations between measures of depression and measures of psychological well-being, ranging from -0.40 to -0.55 (Ryff, 1995), stating that only one quarter of the variance between measures of mental illness and mental health is shared (Frisch et al., 1992).

The need for mental health professionals to support both the reduction of mental illness and the improvement of mental health is highlighted. This includes the development of further skills in the workforce. These skills will be based on new areas of knowledge, each of which have emerged as distinct scientific areas of enquiry only in the past two decades. Mental health and the efforts for its development have been posed to be a new concept whereas it has been underlying to our civilizations for centuries together. It has been uncovered and recognised as a saviour now. Development of mental health is uniformly recognised as an important factor across different ages and sexes.

Well-being may be defined according to the global question about overall life satisfaction and domain specific questions about work, income, social relationship and neighborhood (Baumrind, 1991; Diener, 1984). Well-being is a complex construct that concerns optimal experience and functioning (Ryan & Deci, 2001). Research on well-being consistently reveals that the characteristic resources valued by society correlated with happiness. Well-being refers to what people think and how they feel about their lives to the cognitive

and affective conclusions they reach when they evaluate their existence (Diener, 2000). It is the focus not only of everyday interpersonal inquiries (e.g. “How are you?”) but also of intense scientific scrutiny. Simple questions like, “How are you?” may seem simple enough, theorists have found the issue of well-being to be complex and controversial. Indeed, from the beginnings of intellectual history, there has been considerable debate about what defines optimal experience and what constitutes “the good life”.

Research suggests that well-being and healthy development during adolescence move hand in hand (Larson et al., 2002; Robinson et al., 2003). Family values are challenged as they strive for independence. Other recent findings suggest that at any one time, 10% of the child population is likely to be facing behavioral difficulties severe enough to impact their own functioning and that of their families.

Well being research seems especially prominent in current empirical psychology. This reflects the increasing awareness that, just as positive affect is not the opposite of negative affect (Lu, 1999), well-being is not the absence of mental illness.

The first of these can be broadly labeled hedonism (Kahneman et al, 1999) and reflects the view that well being consists of pleasure or happiness. The second view, both as ancient and as current as the hedonic view, is that well-being consists of more than just happiness. It lies instead in the actualization of human potentials. This view has been called eudemonism (Waterman, 1993), conveying the belief that well-being consists of fulfilling or realizing one's daimon or true nature. The two traditions hedonism and eudemonism are founded on distinct views of human nature and of what constitutes a good society.

Hedonism, as a view of well-being, has thus been expressed in many forms and has varied from a relatively narrow focus on bodily pleasures to a broad focus on appetites and self-interests. Psychologists who have adopted the hedonic view have

tended to focus on a broad conception of hedonism that includes the preferences and pleasures of the mind as well as the body (Kubovy, 1999). Indeed, the predominant view among hedonic psychologists is that well-being consists of subjective happiness and concerns the experience of pleasure versus displeasure broadly construed to include all judgments about the good/bad elements of life. Happiness is thus not reducible to physical hedonism, for it can be derived from attainment of goals or valued outcomes in varied realms (Diener et al., 1998).

Kahneman et al. (1999) defined hedonic psychology as the study of what makes experiences and life pleasant and unpleasant.

Although there are many ways to evaluate the pleasure/pain continuum in human experience, most research within the new hedonic psychology has used assessment of subjective well-being (SWB) (Diener & Lucas, 1999). SWB is a fundamental human concern. Since at least the sixth century BC, the classic Greeks explored the issue under the rubric of eudaimonia, that is human flourishing or living well. This followed with the Hellenistic Greeks and the Romans exploring ataraxia, a form of happiness within one's own control (Larsen, 2000). DeNeve and Cooper (1998) have shown that personality is one of the foremost predictors of SWB, which underscores the importance of using personality to understand happiness. SWB consists of three components: life satisfaction, the presence of positive mood, and the absence of negative mood, together often summarized as happiness.

Although there are various theoretical perspectives associated with hedonic psychology, some of its most prominent proponents have eschewed theory, arguing for a bottom-up empirical approach. Specifically, some have argued that we need to know more “elementary facts before a large theory is created” (Diener et al, 1998). Nevertheless, one can characterize the dominant work in hedonic psychology in theoretical terms, even if they remain implicit. Overall, the theories, whether implicit or

explicit, tend to fit within what Watson and Clark (1992) refer to as the standard social science model, which is built on the assumption of an enormous amount of malleability to human nature. The focus of hedonic psychology on pleasure versus pain also readily links it with behavioral theories of reward and punishment (e.g. Peterson & Hann, 1999) and theories focused on cognitive expectations about such outcome (e.g. Peterson, 2000). The claim of hedonic psychologists can be highly idiosyncratic and culturally specific would also seem to fit well within a relativistic, postmodern view. Thus, although explicit theory is often not endorsed by hedonic researchers, implicit theoretical themes are identifiable.

Aristotle said that true happiness is found in the expression of virtue that is, in doing what is worth doing.

Eudaimonia is valuable because it refers to well-being as distinct from happiness. Eudaimonic theories maintain that not all desires not all outcomes that a person might value would yield well-being when achieved.

Thus, from the eudaimonic perspective, subjective happiness cannot be equated with well-being.

Waterman (1993) stated that, whereas happiness is hedonically defined, the eudaimonic conception of well-being calls upon people to live in accordance with their daimon, or true self. He suggested that eudaimonia occurs when people's life activities are most congruent or meshing with deeply held values and are holistically or fully engaged. Under such circumstances people would feel intensely alive and authentic, existing as who they really are a state Waterman labeled personal expressiveness (PE). Empirically, Waterman showed that measures of hedonic enjoyment and PE were strongly correlated, but were nonetheless indicative of distinct types of experience. For example, whereas both PE and hedonic measures were associated with drive fulfillments, PE was more strongly related to activities that afforded personal growth and development. Furthermore, PE was

more associated with being challenged and exerting effort, whereas hedonic enjoyment was more related to being relaxed, away from problems, and happy.

Self-determination theory (SDT) (Ryan & Deci, 2000) is another perspective that has both embraced the concept of eudaimonia, or self-realization, as a central definitional aspect of well-being and attempted to specify both what it means to actualize the self and how that can be accomplished. Specifically, SDT posits three basic psychological needs: autonomy, competence, and relatedness and theorizes that fulfillment of these needs is essential for psychological growth (e.g. intrinsic motivation), integrity (e.g. internalization and assimilation of cultural practices), and well-being (e.g. life satisfaction and psychological health), as well as the experiences of vitality (Russelle & Saebel, 1997) and self-congruence (Sheldon & Elliot 1999). Need fulfillment is thus viewed as a natural aim of human life that delineates many of the meanings and purposes underlying human actions (Deci & Ryan 2000).

SDT posits that satisfaction of the basic psychological needs typically fosters SWB as well as eudaimonic well-being. This results from our belief that being satisfied with one's life and feeling both relatively more positive affect and less negative affect (the typical measures of SWB) do frequently point to psychological wellness, for as Rogers (1963) suggested, emotional states are indicative of organismic valuation processes. That is, the assessment of positive and negative affect is useful insofar as emotions are, in part, appraisals of the relevance and valence of events and conditions of life with respect to the self. Thus, in SDT research, we have typically used SWB as one of several indicators of well-being.

Applying the two viewpoints

Suggested that the hedonic and eudaimonic foci are both overlapping and distinct and that an understanding of well-being

may be enhanced by measuring it in differentiated ways. Rojas (2006) analyzed a diverse set of mental health indicators and also found two factors, one reflecting happiness and the other, and meaningfulness. These researchers showed that, when pursuing personal goals, doing well and feeling happy may be disconnected from finding meaning and acting with integrity. Thus, in spite of the significant overlap, the most interesting results may be those that highlight the factors leading to divergence rather than just convergence in the hedonic and eudaimonic indicators of well-being.

Ryff (1989) has argued that the preceding perspectives despite their loose conceptualizations can be integrated into a more parsimonious summary. That is, when one reviews the characteristics of well-being described in these various formulations, it becomes apparent that many theorists have written about similar features of positive psychological functioning. These points of convergence in the prior theories constitute the core dimensions of the alternative formulation of psychological well being pursued in this research. They are briefly summarized here (detailed descriptions of the characteristics and how they were derived are available in Ryff, 1989a).

Self-acceptance: This is defined as a central feature of mental health as well as a characteristic of self-actualization, optimal functioning, and maturity. Life span theories also emphasize acceptance of self and of one's past life.

Positive relations with others: The ability to love is viewed as a central component of mental health. Self-actualizers are described as having strong feelings of empathy and affection for all human beings and as being capable of greater love, deeper friendship, and more complete identification with others. Warm relating to others is posed as a criterion of maturity. Adult developmental stage theories also emphasize the achievement of

close unions' with others (intimacy) and the guidance and direction of others (generativity).

Autonomy: Qualities as self-determination, independence, and the regulation of behavior from within. Self-actualizers, for example, are described as showing autonomous functioning and resistance to enculturation. Functioning person is also described as having an internal locus of evaluation, whereby one does not look to there for approval. Individuation is seen to involve a deliverance from convention, in which the person no longer clings to the collective fears, beliefs, and laws of the masses.

Environmental mastery: The individual's ability to choose or create environment suitable to his or her psychic conditions is defined as a characteristic of mental health. Maturity is seen to require participation in a significant sphere of activity outside of self. Life span development is also described as requiring the ability to manipulate and control complex environments.

Purpose in life: To include beliefs the give one the feeling there is purpose in and meaning to life. The definition of maturity also emphasizes a clear comprehension of life's purpose, a sense of directedness, and intentionality. The life span developmental theories refer to a variety of changing purposes or goals in life, such as being productive and creative or achieving emotional integration in later life.

Personal growth: psychological functioning requires not only that one achieve the prior characteristics, but also that one continues to develop one's potential, to grow and expand as a person. The need to actualize oneself and realize one's potentialities is central to the clinical perspectives on personal growth. Openness to experience, for example, is a key characteristic of the fully functioning person. Such an individual is continually developing and becoming rather than achieving a fixed state wherein all problems are solved. Life span theories also give explicit emphasis to continued growth and the confronting of new challenges or tasks at different periods of life.

Thus, continued personal growth and self-realization is a prominent theme in the aforementioned theories.

In sum, the integration of mental health, clinical, and life span developmental theories points to multiple converging aspects of positive psychological functioning.

Adolescence is generally considered to be a time of transition from childhood to adulthood that involves significant changes in social and emotional development, behavior and cognitions. Yet adolescence is also a period of great joy, excitement and optimism during which the delights of autonomy, intimacy and the future are fresh and possibilities are created for happiness, success and psychological growth, throughout the remainder of life. Within their creativity, energy and enthusiasm young people can change the world in astonishing ways making it a better place not only for themselves but for everyone (Goodburn & Ross, 1995). It is probably the most turbulent, challenging, stressful and uncertain of all phases in life. When adolescents are supported and encouraged by caring adults, they thrive in extinguished ways becoming resourceful and contributing members of the families and communities. This is the state when they are bursting with energy curiosity and spirit that are not easily extinguished.

As interpersonal relationships influence an individual's wellbeing, stable and secure relationships with family and peers can assist adolescents in making a smooth transition (Carver, 2003).

Happiness and personality

People who are gregarious, active and outgoing tend to experience more pleasant emotions than those who are quiet, inactive and introverted (Costa & McCrae, 1995).

Researchers have seemed to locate the core of extraversion in the area of pleasant affect (Cross and Madson, 1997).

DeNeve and Cooper (1998) examined the distinct personality constructs as correlates of SWB and happiness. The traits most closely associated with SWB were repressive defensiveness, trust, emotional stability, locus of control - chance, desire for control, hardiness, etc. Neuroticism was the strongest predictor of life satisfaction, happiness and negative affect. Positive affect was predicted equally well by Extraversion and Agreeableness.

DeNeve (1999) suggested that Subjective Well Being and Happiness are determined to a substantial degree by genetic factors and argued that SWB and Happiness are relatively stable across the life span.

DeNeve (1999) reported that extraversion and agreeableness were consistently and positively associated with happiness, whereas neuroticism was consistently negatively associated with it.

Lu (1999) examined the personal and environmental causes of happiness. Lu analyzed an integrative model of happiness, which incorporated personal factors (demographics, extraversion) neuroticism and locus of control) and environmental factors (life events and social support). Results found that extraversion is not directly related to happiness but both neuroticism and internal control had direct effects on happiness.

Diener et al. (2006) reported that one of the most consistent findings in the study of personality and emotions are that extraversion is moderately correlated with pleasant affect.

Aim of the study

The aim of the present study was to study gender differences in mental health and for this purpose one dimension of mental health (well being was taken into consideration. So gender differences in Subjective Well-Being and Psychological Well-Being was to be studied.

METHOD

Participants

The sample consisted of 200 adolescents (100 males and 100 females). The age-range of the adolescents was 14-17 years and they were selected randomly from Private schools of Delhi NCR.

Instruments

Satisfaction with Life was measured by using Satisfaction with Life Scale developed by Diener et al. (1985), and Positive and Negative Affect Schedule (PANAS), developed by Watson et al., (1988) were used to measure the Subjective Well Being.

Psychological Well Being scale devised by Ryff and Keyes (1995) was used to measure Psychological Well Being, which has six dimensions of Wellness viz. Autonomy, Environmental Mastery, Personal Growth, Positive Relations With Others, Purpose In Life and Self Acceptance.

Brief description of tests

Satisfaction with Life Scale (Diener et al., 1985): It is a five-item scale that is designed around the idea that one must ask subjects for an overall judgment of their life in order to measure the concept of life satisfaction. Individuals indicate their degree of agreement or disagreement on a 7 - point Likert scale with 7= strongly agree to 1=strongly disagree scores range from 5 to 35. Diener et al. (1985) reported a 2-months test-retest correlation coefficient of .82 and an alpha coefficient of 0.82 and an alpha coefficient of 0.87 for undergraduates. Diener et al. (1985) also reported it to be a valid test.

Positive and Negative Affect Schedule (PANAS) (Watson et al., 1988): Positive and Negative Affect Schedule (PANAS) was developed by Watson et al. (1988). While developing the scale the greatest concern of the authors was to select terms that were relatively pure markers of either Positive Affect (PA) or

Negative Affect (NA). Finally 20 items scale, which were internally consistent and had excellent convergent and discriminant validity with lengthier measures of the underlying mood factors were developed. They also demonstrate appropriate stability over a two-month time period. The alpha reliabilities range from 0.86 to 0.90 for Positive Affect and from 0.84 to 0.87 for Negative Affect. The scale consists of a number of words that describe different feelings and emotions. Each word is rated on a 5-point rating scale, according to the extent to which the subject felt that way during the past few weeks. The scale ranges from 1 - 'very slightly or not at all' to 5 - 'extremely'.

The scales correlate at predicted levels with measures of related constructs and shows the same pattern of relations with external variables that have been seen in other studies. E.g. the PA scale (but not the NA scale) is related to social activity and show significant diurnal variation, whereas the NA scale (but not the PA scale) is significantly related to perceived stress and shows no circadian pattern (Watson et al., 1988). Thus the Positive and Negative Affect Schedule is a reliable and efficient mean for measuring these two important dimensions of mood. This scale was used in India by Maini (2001), Mohan (2002) and Salariya (2006).

Psychological Well Being Scale (Ryff and Keyes, 1995): It was measured by using Ryff and Keyes (1995) scale of Psychological Well Being with six dimensions: Autonomy, Environmental Mastery, Purpose in Life, Self Acceptance, Personal Relations with Others and Personal Growth. Each subscale of this scale has three items measuring each of these six dimensions. Some items are worded positively and some are worded negatively. Individuals rate themselves on a 6 point Likert-type scale with response pattern ranging from strongly disagree to strongly agree". Negative items are reversed so that a high score indicates that the person has a positive perception of their own Psychological well being. Thus the scores on each

subscale can range from 3-18. Scale inter-correlations are modest ranging from 0.13 to 0.46. Estimates of internal consistency coefficients are low to modest, ranging from 0.33 to 0.56.

It has been successfully used in West by Cooper et al. (1998), Schmutte and Ryff (1997), Rye et al. (2004), Frazier et al. (2005), Lawler and Peferi (2006).

RESULTS

Mean, SD and t-ratio was computed to find significant differences on various components of Well-being among males and females.

The primary aim of the present investigation was to study the gender differences on differential measures of well-being viz. Happiness, Subjective Well-Being and Psychological Well-Being. Means, Standard Deviations and t-test were calculated for Male and Female Adolescents. Significant t-values were Positive Affect ($t=3.02$, $p<0.05$), Self acceptance ($t=3.05$, $p<0.05$) and Perceived Happiness Status ($t=3.04$, $p<0.05$). It was also found that females scored higher on all these variables of well being and happiness, thus overall on mental health.

DISCUSSION

Gender differences: Research evidence shows that men are not born less emotionally expressive than women but in fact the teaching and internationalization of socially proscribed gender norms influence the experience, expression, and regulation of specific emotions (Brody, 1999, 1999; Levant & Kopecky, 1995).

Women tend to receive greater social support from peers compared with men (Eagley & Crowley, 1986). Women also possess a greater tendency to recognize acts of goodwill by others, express their appreciation, and reinforce the likelihood these acts will be repeated. Upon encoding these shared positive experiences, a durable social resource is created with both parties

more likely to respond with variants of support and responsiveness when later faced with adversity.

Women are generally more expressive than men, and with the exception of anger, experience emotions more intensely and frequently compared with men (Diener et al., 1991; Grossman & Wood, 1991; Kring & Gordon, 1998; Gonzalez et al., 2005; Caprara & Steca, 2004).

For example positive emotions can aid human beings in their quest to satisfy the fundamental need to be accepted by other people (Baumeister & Leary, 1995).

On average, women also report a greater willingness to express them openly and show stronger tendencies to regulate their emotions to adapt to changing social circumstances compared with men (Greenglass et al., 1998). Small to moderately sized differences between men and women in the experience and expression of emotions are contingent in multiple social, emotional, interpersonal and contextual factors.

Although there was no support for emotion expressiveness as a mechanism of action in men. Earlier women in general are more willing than men to expressing emotions (Kring & Gordon, 1998).

Men's preference for concealing emotions in general seems culturally proscribed with the expression of gratitude being associated with additional negative evaluated feeling of vulnerability, dependence: or indebtedness. An unwillingness to be in with negatively evaluated emotions may lead to efforts to avoid, conceal, or alter the emotional experience at the expense of other values or psychological benefits (Hayes et al., 1999). Men's preference to avoid feelings of perceived vulnerability or indebtedness costs them opportunities to develop and strengthen relationships with others. Women are more aware of their emotions and report more complex emotional experiences compared with men (Barrett et al., 2000).

Differences in the experience and expression of positive emotions may amplify the benefits for women compared with men. Positive emotions feel good, serve the function of broadening people's mindsets, and allow for finite attentional resources to be re-directed from unrewarding goals to other desired and more meaningful opportunities (Carver, 2003; Fredrickson et al., 2005).

According to a study conducted in India, Singhal and Rao (2004) found that there are only nominal difference in the overall psychological concerns of males and females (Males-38.56%, Females-38.77%), indicating that psychological problems pervade all adolescents, irrespective of gender, but there are differences between male and females on components of it.

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Assertiveness among Undergraduate Students of the University

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ABSTRACT

Assertiveness is a mode of personal behavior and communication characterized by a willingness to stand up for one's needs and interests in an open and direct way. When an individual stands for his/her rights without violating the rights of others, he/she is being assertive (Smith 1975). When you adopt assertive behaviour you get more of what you want, but only when you acknowledge and give consideration to what the other person wants or needs. It's the paradox of win-win that makes it possible (Conrad & Suzanne Potts). The present study is an attempt by the researcher to examine the assertiveness level of undergraduate students with reference to their gender, residence and stream of study. The sample of the present study is comprised of 100 undergraduate students (50 males and 50 females) within the age group between 16 to 22 years and has been the students of following courses; Bachelor of Arts, Science and Commerce. The Rathus Assertiveness Schedule (1978) was used to study the level

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of assertiveness among the selected students. The results of the study revealed no significant difference between students in their level of assertiveness with respect to gender, residence and Stream of study. During the analysis it was ascertained by the researcher that among 100 (students) respondents, 11 were 'situationally non assertive', 35 'Somewhat assertive', 45 'Assertive', and 9 were 'probably aggressive', irrespective of their gender, residence and education. Based on the findings of the study it is recommended by the researcher that a programme regarding assertiveness training should be conducted in the future.

Keywords: *Assertiveness; Undergraduate Students*

Assertiveness is an important social skill which promotes personal well-being. Most definitions of assertiveness emphasize direct expression of feelings, desires and thoughts in interpersonal contexts. Definitions of assertive behavior put an emphasis on individual rights. Alberti and Emmons (1990) stated that "assertive behavior promotes equality in human relationships, enabling us to act in our own best interests, to stand up for ourselves without undue anxiety, to express honest feelings comfortably, to exercise personal rights without denying the rights of others. Assertiveness is a mode of personal behavior and communication characterized by a willingness to stand up for one's needs and interests in an open and direct way. The assertive person stands up for things that matter to him or her while at the same time respecting the things that matter to others (Zimmerman and Luecke, 2010). Assertiveness has also been defined as the process of direct and appropriate communication of a person's needs, wants and opinions without punishing or putting down others (Arrindell and Ende, 1985). It can be used as an instrument for initiating and maintaining socially supportive relationships and hence enjoying better emotional wellbeing (Eskin, 2003).

Assertiveness was considered to be a mean of self-development and achievement of maximum personal fulfillment and assertive skills in various communication fields in conjunction with the increased demands on social competence of the individual (Ivelina and Mavrodiev, 2013).

Assertiveness as a social skill is a construct which has a number of different dimensions, including the ability to express oneself without anxiety or aggression in different situations (M. Bouvard, et al., 1999). Assertiveness is about effective communication and this does not just mean choosing the right words to say in a given situation. Tone of voice, intonation, volume, facial expression, gesture and body language all play a part in the message you are sending to the other person, and unless all parts of the equation match, you will be sending a garbled message (Bishop, 2000). According to Galassi and Galassi (1978), “assertion is the direct and appropriate communication of a person’s needs, wants and opinions without punishing, threatening, putting down others, and doing this without fear during the process.”

Statement of the problem:

Today’s adolescents are tomorrow’s leaders and this naturally calls for the shaping of their behaviour. Many adolescents find it difficult to express themselves effectively in social situations. This undermines their significant role in the development of modern India and also in improving and strengthening the society. They are the pillars of a nation and play an important role in contributing much to its social development. So it is important for an adolescent to be assertive, because being assertive can help them in many ways. It helps them in improving self confidence, self-esteem and also helps them to stand up for their rights without being aggressive and without violating the rights of others. Studies in assertiveness among gender have reported contradictory findings like; (Eskin, 2003; Qadir &

Sugumar, 2013; Uzaina & Parveen, 2015; Rathee, 2015, & Applebaum, 1976) did not find sex differences in assertiveness among adolescents. While (Prakash & Devi, 2015; Hersen et al, 1973) reported that males were more assertive. Other findings like (Chandler et al, 1978) found that women were significantly more assertive than men in some specific situations. To this end, the conducted study was designed by the researcher to find out the assertiveness level among adolescents with reference to their gender, residence and stream of study. This will be helpful in further identification of the areas of assertiveness to work upon.

Objectives of the study:

- To find out the level of assertiveness among students.
- To find out whether there is any significant difference in their assertiveness based on the following demographic variables:

- (1) Gender
- (2) Residence
- (3) Stream of study

Hypothesis:

H1: Students will significantly differ in their assertiveness score.

H2: Students will significantly differ in their assertiveness with reference to Gender.

H3: Students will significantly differ in their assertiveness with reference to Residence.

H4: Students will significantly differ in their assertiveness with reference to Stream of study.

METHOD AND PROCEDURE

Sample:

The sample of the present study comprised of 100 adolescents both urban and rural (50 males and 50 females). They belong to age range of 16 to 22 years and were undergraduate students of following courses- Bachelor of Arts, Science and Commerce.

Tool used in the Study:

The Rathus Assertiveness Schedule (1978) was used to study the assertiveness of adolescents. It is a standardized tool comprising 30 situational statements for which the subject is asked to rank the degree to which each statement is characteristic and descriptive of his/her behaviour (—3 to +3) yielding a total assertiveness score between — 90 (least assertive) and + 90 (most assertive). The tool was administered individually to each student and care was taken to see that the adolescents filled the questionnaire without discussing. There was no time limit for completion of the scale.

Scoring:

The Researcher used the six-point rating scale to score the responses. Here, the subjects were asked to rate their responses by mentioning a number between 1 and 6 which described them most accurately, against each item. Where 1 stood for once in a great while & 6 stood for always. The information provided by the respondents in the personal data sheet was numerically coded to suit the computer analysis. Their responses were further weighed on a scale ranging from +3 to -3 which on being summated for each item yielded a final score falling anywhere between +90 and -90. On the basis of this final score, it was convenient for the researcher to categorise the respondents on the basis of their level of assertiveness.

Statistical Techniques Used: In the present study the Researcher used the following statistical techniques:

1. Descriptive Analysis (Mean, Standard Deviation)
2. Differential Analysis (t-value, F-ratio)

RESULTS AND ANALYSIS***Table 1: Group difference on Assertiveness with respect to their Category***

Variable	Background Variables	Sources of Variation	Df	Sum of Squares	Mean Squares	F - ratio	Level of significance
Assertiveness	Category	Between Group	3	21353.631	7117.877	209.663	S
		Within Group	96	3259.119	33.949		
		Total	99	24612.750			

The result presented in table 1 indicated that there is significant difference in assertiveness with respect to their category. In this way, the first finding of the study supports our hypothesis. According to the result there is significant difference on assertiveness score between students.

Table 2: Showing the 't' - value on Assertiveness with respect to Gender

Gender	N	Mean	Std. Deviation	t	Sig.
Female	28	29.0357	5.87198	.283	NS
Male	17	29.5294	5.31646		

The above findings revealed that no significant difference found in assertiveness with respect to gender. In this way our second hypothesis was rejected and the null hypothesis retained as the t- value indicated no significant difference between boys and girls.

Table 3: Showing the 't' - value on Assertiveness with respect to Residence

Gender	N	Mean	Std. Deviation	t	Sig.
Rural	20	29.5500	6.03041	.347	NS
Urban	25	28.9600	5.36563		

The results presented in Table- 3 reveals that no significant differences in assertiveness exist between rural and urban students. The third hypothesis was also rejected and the null hypothesis retained as the t-value indicated no significant difference with respect to residence.

Table 4: Group difference on Assertiveness with respect to Stream of study

Level of significant	F-ratio	Mean Squares	Sum of Squares	Df	Sources of Variation	Background Variables	Variable
NS	.314	10.217	20.443	2	Between Group	Education	Assertiveness
		32.508	1365.344	42	Within Group		
			1385.778	44	Total		

From the above findings the result revealed that there is no significant difference between arts, science and commerce students in their assertiveness with respect to their Stream of study. But the findings also revealed that commerce students have better assertiveness score than arts and science students. Hence our fourth hypothesis was also rejected and null hypothesis retained as the analysis of variance shows no significant difference in their assertiveness with respect to their stream of study.

DISCUSSION

Present research was done to investigate the assertiveness among undergraduate students with respect to their gender, residence and stream of study. The first hypothesis of the present study was retained which shows a significant difference on assertiveness score among students. In addition to that the findings also revealed that no significant difference was found in

assertiveness with respect to gender. Though we generally assumed that girls are less assertive than boys because of cultural taboos and inhibitions. Men tend to be more assertive because they are considered to be having a strong and thoughtful personality. Some studies with college students have supported this assumption like Chandler, Cook and Dugovics (1978), Kimble, Marsh and Kiska (1984), and Adejumo (1981) with Nigerian university students found men to be more assertive than women. But, this study revealed that girls are equally assertive as the boys. The finding of this study are supported by previous researchers, Eskin (2003), Qadir and Sugumar (2013) and Uzaina & Parveen (2015) whose results revealed no significant gender difference in assertiveness. The third finding of the study revealed that no significant differences in assertiveness exist between rural and urban students. Infact we generally assume that locality is known to be a strong factor in contributing to the level of assertiveness in adolescents. But this study revealed no significant difference between boys and girls with respective to their residence. The study also revealed that there is no significant difference between arts, science and commerce students in their assertiveness with respect to their Stream of study. But the findings revealed that commerce students have better assertiveness score than arts and science students. Hence our fourth hypothesis was also rejected and null hypothesis retained as the analysis of variance shows no significant difference in their assertiveness with respect to their stream of study.

CONCLUSION

The present study revealed that there is no significant difference among students with respect to their gender, residence and stream of study. But it is confirmed that there is significant difference among students in their assertiveness score. During the analysis it was found that among 100 (students) respondents, 11 were 'Situationally non assertive', 35 'Somewhat assertive', 45

‘Assertive’, and 9 were ‘probably aggressive’. Based on the above findings it is clearly indicated that there is lack of assertiveness among students. So, for an adolescent to develop into a complete adult it is highly imperative to teach him some coping strategies and one of the most important and useful skill is assertiveness. By inculcating this skill an adolescent will be able to express both positive and negative feelings honestly and straightforwardly, without anxiety or intimidation. As a conclusion an assertiveness training could be beneficial for developing adolescents’ assertive behaviours and this enhancing program could be incorporated into everyday curriculum in schools, colleges and universities. The study may helpful for the students to understand the level and importance of assertiveness. In addition a programme regarding assertiveness training should be conducted in the future.

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Juvenile Delinquency as a Behavioural Problem

Priyanka Yadav^{1*}

ABSTRACT

Juvenile can be defined as a child who has not attained a certain age at which he, like an adult person under the law of the land, can be held liable for his criminal acts. The juvenile is a child who is alleged to have committed /violated some law which declares the act or omission on the part of the child as an offence. The causes of juvenile delinquency are varied. The concept of delinquency also varies with the point of view of the people who feel challenged by it. Ferdinand presented two categories of juvenile offenders: Neurotic Offender and Character disorder offenders. Various theories behind delinquency like Psychogenic theory, Motivational theory, Psychoanalytical, Psychiatric theory and Medico-Biological theory are explained. Causes behind delinquency are explained in terms of biological, socio-environmental, psychological, physiological and personal causes. Behavioural characteristics in which delinquents have been found to cluster into behavior dimension sub-groups. In a series of multivariate research projects Quay (1987) has shown that there is a similarity to these dimensions of behaviour in juveniles to categories defined by researchers of child psychopathology.

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Prevention is necessary for such children. First of all, we should identify such juveniles and thereafter give him treatment. They will become habitual offender if they are not timely prevented from committing the offence. The most effective way to prevent juvenile delinquency has indisputably been to assist children and their families early on. For late blooming delinquency, broad-based programmes may be needed that address the individual, peer group, family and community. Parents are also counseled to learn the importance of monitoring their children more closely. Numerous state programs attempt early intervention, and federal funding for community initiatives has allowed independent groups to tackle the problem in new ways. Preventive programmes of delinquents including individual and environmental programmes have been suggested. Role of police, enforcement of law, aftercare and rehabilitation programmes along with the role of counseling in delinquents have been stressed upon.

Keywords: *Juvenile Delinquency, Behavioural Problem*

Juvenile can be defined as a child who has not attained a certain age at which he, like an adult person under the law of the land, can be held liable for his criminal acts. The juvenile is a child who is alleged to have committed or violated some law which declares the act or omission on the part of the child as an offence. The word delinquency is derived from the Latin word “delinquere” meaning de i.e. away and linquere i.e. to leave thus, meaning to leave or to abandon. Originally, the word had an objective meaning as it referred to parents who neglected and abandoned their children¹. Delinquency is an act or conduct of a juvenile which is socially undesirable. Juvenile delinquency generally means the failure of children to meet certain obligations expected of them by the society². The juvenile delinquency is

expression of unsatisfied desires and urges. For a delinquent, his deviant act is a normal response to his inner desire. Like a non-delinquent a delinquent is also conditioned by various attending and prevailing circumstances around him.

The causes of juvenile delinquency are varied. The concept of delinquency also varies with the point of view of the people who feel challenged by it. According to a social worker, "delinquency consisted of socially unaccepted acts". A psychiatrist suggests that delinquent behavior is activity which deviates from the normal. And a lawyer would say juvenile delinquency is what the law says it is. In the words of W.H. Sheldon, it is "behavior disappointing beyond reasonable expectation". It becomes difficult to determine where exactly the approved behavior ends and where from the disapproved begins³.

Ferdinand presented two categories of juvenile offenders as under:

(1) **Neurotic Offenders**- They are the offenders whose delinquency is the result of powerful unconscious impulses which often produces guilt which in turn, motivates them to act out their delinquency in their community so that they will be caught and punished. The delinquent act is sometimes considered symbolic. For example, if they steal, it is done for love and not for a material gain. To such delinquents, delinquency is a way of handling their internal problems by externalizing the problem within the environment.

(2) **Character Disorder Offenders** - This type of offenders feel very little guilty when they commit the acts of delinquency. Because of a lack of positive identification models in their environment, they have failed to develop self-control and do what they want to do when they feel like doing it. They are unable to sublimate their impulses in a socially acceptable manner. They have not developed an adequate conscience structure or superego. They come from disorganized families and have had a barren

environment in their childhood. They are self-centered and feel to be aloof and have difficulty in forming meaningful relationships⁴.

Schafer emphasized on psychological typologies and psychological dynamics of personality as the basis of classification of juvenile delinquents which are as follows:

(1) Mentally Defective

This is an individual who has an organic problem and who has difficulty in controlling himself because of it. For example, offenders who are mentally defective are involved in petty crimes. This category also includes mentally retarded youngsters.

(2) Situational Offenders

They are similar to the accidental offenders but, in these cases, there are more contributing factors. Their delinquency is precipitated by a crisis or by some external event which they are unable to handle. In other words, they do not necessarily go out looking for trouble but because of tempering circumstances, they do not use good judgment.

(3) Psychotic Offenders

A small number of youngsters do not have contact with reality. They may be classified as schizophrenic or may be given some other psychiatric label. As a result of dysfunctional thought patterns, they may hallucinate, have delusions or "hear voices" that command them to become involved in certain types of delinquent behaviour. The incidence of psychotic oriented delinquency is minimal in relation to the other forms.

(4) Cultural Offenders

Youngsters in this category have either emulated a faculty identification model or they live in an economically and socially deprived environment. Cultural offenders are considered normal members of a deviant sub-culture and their patterns of behaviour are often accepted and called normative in their own environment⁵. The problem of child (juvenile) delinquency like many other social evils is linked up with the imperfections and maladjustment of our society and is also connected with the

present day system of education to some extent. This system aims more at the training of the intellect than the education of the emotions which play such a vital part in the formation of the pattern of the child's behaviour and personality. But the idea is gradually gaining wider acceptance that the juvenile delinquent needs the sympathy and understanding of the society and social agencies and not the heavy hand of the law⁶.

(A) Psychogenic Theory - In general, this theory stresses the psychological pathology of the delinquent.

(B) Motivational theory which emphasize that legitimate desires that conformity, cannot satisfy force a person into deviance⁷.

(C) Psychoanalytical and Psychiatric Theory –Airchornasserted that there must be something in child himself which environment brings out in the form of delinquency. Delinquents behave as they do because they are in some way “Maladjusted” persons. Airchron's statement indicates further that the environment may function as a precipitating force, but never as primary force in causation⁸.

(D) Medico-Biological Theory - This theory include the hereditary factors, chemical balances within the physical organism, and certainly the influence of physical illness on behaviour⁹.

CAUSES: There is no single cause of Juvenile delinquency but there are many and varied causes. Basically, causes of Juvenile delinquency are of three types.

- ☐ Biological
- ☐ Socio-Environmental
- ☐ Psychological, Physiological and personal

A. Biological Causes: Ocular Ailments, Nose and throat problem, Hearing Problem, Speech Problem, Enuresis, Irritation, Headache, Excessive strength, Hypoglycemia^{10,11,12,13}.

B. Socio-Environmental: Mobility, Cultural conflicts and Family background and Family structure^{14,15}. Some are the factors which emanates from the family background are as under:-

(a) Family Structure and Broken Homes

Family is considered to be the most effective variable in socializing the child and also in serving as a source for learning various types of behaviour. The nature and structure of the family are largely responsible for carving out the personality make-up of the children. Shaw and McKay⁶⁴ (1932), Weeks and Smith (1939), Glueck and Glueck (1950), Browning (1960), Peterson and Becker (1965) have reported in their studies the relationship between broken home and delinquency. Badami (1965) considered broken homes with other factors, such as, poverty, lack of recreational facilities, disorganized family, including family conflicts, and neglect of children to be the important factors causing juvenile delinquency^{16,17,18,19,20}.

(b) Child's Birth Order in the Family/Family Size and Type

Lees and Newson (1954) found differences among the delinquents which could be attributed to sibling position. Their study showed that intermediate children having both older as well as younger siblings were significantly overrepresented in a group of delinquents. Glueck (1950) found delinquent boys were more often from larger families.

(c) Parent-Child Relationship

The pattern of interpersonal relationship with a family is important in shaping the inter-personal behaviour and cognition of the child (Glueck and Glueck, 1950 and Nye, 1958). Bandura and Walters (1956) found that the interpersonal relations between aggressive delinquent boys and their parents were at the behaviour level, characterized by a lack of dependency on the part of the son²¹.

(d) Behaviour of Step and alcoholic Parents

(e) Excessive punishment

(f) Constant Quarrel / Exploitation of Children by their parents^{22,23}

(g) Socio-economic condition / Alcohol/Intoxication/ Peer Group/ Cinema /Role of Press^{24,25,26}

(h) Mental make-up - Mental make-up of the child also conditions his behaviour to a large extent. Various researches reveal that a large proportion of delinquents are feeble minded and deficient in intelligence.

(i) Heredity - The factor of heredity is emphasized a lot when studying the cause of delinquent behaviour. According to Goring, feeble-mindedness is the result of hereditary transmission²⁷.

C. Psychological, Physiological and personal

Psychological and neuro-physiological conditions and ailments, ocular ailment, nose and throat obstructions, eating trouble, speech defects, physical irritations excessive physical strength mental disorder etc; as in the case of normal behaviour, the delinquent behaviour is also affected by intellectual factors. It is commonly observed that intelligent persons in teenagers perform delinquent acts in rather refined manner. Early studies by Goring (1913), Goddard (1921), found low intelligence as the single factor influencing juvenile delinquency. In India, Kundu (1969) found delinquents to be of inferior intelligence. In contrast, some researchers have found delinquents to be more intelligent. Muthayya and Bhaskaran (1964) found delinquents to be slightly more intelligent than normals. The personality traits, such as neuroticism, psychoticism, frustration and maladjustment appear to be important causative factors of juvenile delinquency. Hinderlang (1971) found delinquents to be more neurotic than non-delinquents. Shanna (1979) found delinquents to be highly frustrated. They were reported to have higher scores on regression and aggression. Moreover, Basu (1984) on the basis of his study pointed out that emotional instability, insecurity, feelings of inadequacy (both in respect of primary and secondary needs) and

inferiority are common denominations or behaviour disorders in juvenile delinquency. Healy and Bronner (1936) found that delinquents were either rejected, deprived or insecure. Russell (1977) found that neuroticism, depression, sensitivity, impulsivity, social extroversion and social non-conformity were dominant personality characteristics in juvenile delinquents. Delinquents have often been observed to be rigid in their behaviour and do not easily change their pursuits. Sivanandam (1990) in her study indicated that the girl delinquents and women criminals were high on introgression blame avoidance, evading frustration, need persistence, group conformity rating and low on obstacle dominance²⁸.

Behavioural Characteristics of Delinquents

Delinquents have been found to cluster into behavior dimension sub-groups. In a series of multivariate research projects Quay (1987) has shown that there is a similarity to these dimensions of behaviour in juveniles to categories defined by researchers of child psychopathology. These dimensions referred to above include under-socialised aggressive, which is seen to involve destructive and aggressive behaviour similar to conduct disorder, and which produces elevated externalising scores on the Achenbach Youth Self-Report. A second grouping is the socialised-aggressive dimension which describes juveniles who associate with delinquent peers. A third dimension is that of immaturity-attention deficit which is akin to hyperactivity, and the last dimension is anxiety withdrawal, which is internalising in character and associated with such scales on the Achenbach Youth Self Report^{29,30}.

Prevention of Juvenile delinquency

Prevention is necessary for such children. First of all, we should identify such juveniles and thereafter give him treatment. They will become habitual offender if they are not timely

prevented from committing the offence. The most effective way to prevent juvenile delinquency has indisputably been to assist children and their families early on. Numerous state programs attempt early intervention, and federal funding for community initiatives has allowed independent groups to tackle the problem in new ways. The most effective programs share the following key components. There are so many Jurists and criminologists who suggested many provisions for the prevention of juvenile delinquency. Some of the provisions are very useful for the welfare of the juveniles and their development.

Delinquency Prevention is the broad term for all efforts aimed at preventing youth from becoming involved in criminal, or other antisocial, activity. Increasingly, governments are recognizing the importance of allocating resources for the prevention of delinquency. Prevention services include activities such as substance abuse education and treatment, family counseling, youth mentoring, parenting education, educational support, and youth sheltering.

Preventive Programmes of Juvenile Delinquency

There may be two kinds of programmes for preventing the juvenile delinquency;

(i) Individual Programme

Individual programme involves the prevention of delinquency through counseling, psychotherapy and proper education.

(ii) Environmental programme

Environmental programme involves the employment of techniques with a view to changing the socio-economic context likely to promote delinquency.

These two forms of preventive approaches are reflected in the following strategies, which are adopted in crime prevention programmes.

(i) Individual Programme

(a) Clinical programme

The object of this clinic is to provide aids through Psychiatrists Clinical Psychologists and Psychiatric Social workers to help the Juveniles delinquents in understanding their personality problems. Taft and England have listed the function of clinics as follows

- ☐ To participate in discovery of pre delinquents.
- ☐ To investigate cases selected for study and treatment.
- ☐ To treat cases itself or to refer cases to other agencies for treatment.
- ☐ To interest other against in Psychiatrically oriented types of treatment of behavioral disorders in children.
- ☐ To reveal the community unmet needs of children.
- ☐ To cooperate in training of students intending to specialize in treatment of behavioural problems³¹

(b) Educational Programme

The impacts of educational institutions are very significant in the countries where almost every child going to school and preventive programme can be launched in an effective manner through the schools. Teachers should not discriminate among the students; they should be treated equally and provided the moral education which is very helpful to the students for their life stand. Moral education is a significant factor for the students, which decide their life. They should be able to understand the difference between right and wrong ideas which are favourable for them and which are not.

(c) Mental Hygiene

This method is also helpful in prevention and treatment of Juvenile delinquency. To prevent the mental conflict and to bring about a proper mental adjustment in childhood and value of mental therapy in curing a mental disturbance cannot be over-emphasized. The mission of life must be determined and energies must be directed towards the fulfillment of the high mission. Development of high sentiment and values in child also prevent Juvenile Delinquency. In October 1944, on occasion of inauguration of the Indian Council for Mental Hygiene Dr. K.R.

Masani, the then Director of Indian Institute 72 of Psychiatry and Mental Hygiene, said that the application of mental Hygiene was wide and varied and in Education, Law, Medicine, Public health, Industry, mental hygiene played an important role in preventing the delinquency and crime.

(d) Parent education

Every community should ensure opportunities for parental educations, which will help making good homes, improve family relationship, and education and care of children. Some educational programmes inform parents on how to raise healthy children.

(e) Recreational programmes

The recreational programmes are a good check on delinquency. Recreation programs enable youths to mix up with other adults and children in the community and develop friendship. Such positive friendships may assist children in later years. Youth programs are designed to fit the personalities and skills of different children and may include sports, dancing, music, rock climbing, drama, karate, bowling, art, and other activities. It is believed that the energies of youth can be very well channelised into pursuits like sport games and other healthy activities, which would counteract delinquent among the participants. The establishment of recreational agencies like sports, playgrounds community centers, concerts drama, puppet shows are very necessary for preventing the delinquency and developing social group work and youth groups. In rural areas, recreational agencies should provide open air meeting halls, playgrounds for sports and cultural activities. Youth organizations and groups/agencies should take and assume the responsibility for organizing these programmes so that Juvenile may be kept away from delinquency.

(f) Removal of inferiority complex

Inferiority complex, fear, apprehension may sometimes lead the child to commit crime under wrong and misplaced

belief/impression of proving himself. Children deserve encouragement to become confident and good spirited person. Discouragement pulls them behind in their life. They should be properly to face various good and bad phases of life and their failures should not be criticized. Praise cheer, sympathy and love should be showered to banish inferiority complex³².

(ii) Environmental programme

(a) Community Programmes

The basic aim of community programme is to reach the people in need of help instead of people approaching the workers and agencies. Another significance of this programme is that the participation of the local community is considered to be more important and role of professional leadership is sought to be kept at the minimum level. Marshal B. Clinard has outlined the key supposition of these programmes as follows :

- ☐ Local people will participate in efforts to change neighborhood conditions.
- ☐ And they do not accept an adverse social and physical environment as natural and enviable
- ☐ Because self-imposed changes in the immediate Environment will have real significance to the resident and consequently will have more permanent effect^{33,34}.

(b) Publicity

This method can also be very useful in preventing the Juvenile Delinquency. The newspapers, magazines, radio, television and motion pictures etc. should show the juvenile delinquency in proper perspective honestly and should also present real reports about the various wrong done by the juveniles and analyze its true causes and also protect the juvenile against false and misleading reporting. The actual position should be presented and produced before the society about their delinquent behavior so that they may be properly assessed.³⁵

(c) Parental love and affection

Child needs unconditional, immediate and true love, care and protection of his mother and father. On account of deprivation of such love and care the child may develop frustration and dissatisfaction leading to crime. So parental love, care and protection is very necessary for the child to prevent him from committing or doing the crime.

(d) Family Environment

Family factors which may have an influence on offending includes the level of parental supervision, the way parents discipline a child, parental conflict or separation, criminal parents or siblings, and the quality of the parent-child relationship. Many studies have found a strong correlation between a lack of supervision and offending, and it appears to be the most important family influence on offending.

Role of Police

The police have an important role in apprehending and protection of juvenile delinquents. The police have more contact with the juvenile than any other agency dealing with the juvenile delinquents. The police is a separate agency from the Juvenile Court and it is also guided and directed by the policies and philosophies of the Juvenile Court with which the police has to work. Thus, in order to understand the police's behavior towards Juveniles, it is essential to understand all the facts of the Juvenile Court.

Enforcement of Law

Constant surveillance is one of the ways in which law and order is maintained and delinquency and crime is substantially reduced in amount and seriousness. The regulatory activities are protective as well as preventive. Regular inspection and investigating may reduce the crime and delinquency in the places. If supervision by the police reduces or eliminates the illegal

activities of adults, juvenile delinquency will also be decreased substantially particularly on public places³⁶.

Aftercare and Rehabilitation programmes

Most of the children released from special schools and other such institutions find themselves in need of great help for their rehabilitation in the community. They immediately require some shelter and a reasonable support and proper guidance for their settlement in the society and return in the main stream. Few other neglected and uncontrollable children also require some temporary help till they are taken back by their parents / guardians³⁷.

ROLE OF COUNSELLING

Researchers (Hawkins 1987; Reid 1993; Yoshikawa 1994) have suggested that early prevention programmes, specifically before school entry hold the greatest promise for early starters. Prevention efforts that begin before school entry may focus almost exclusively on parents and their child rearing practices. It is, therefore, counseled that parents management training centers be established in various communities. In these centers parents may receive training on how to interact differently with their children. Strategies may be geared towards early prevention and alternation of harsh and inconsistent parenting, waiting until youth commit their first crime may be too late for preventing this type of delinquency.

Parents Management Training aimed at improving health care, parents' involvement and counseling to parents may be introduced in these centres. Training may include a daily 1-2 hours class-room sessions for children, a weekly home visit to each mother and child that attend the programme and a monthly parents meetings to assess the success of the training. The home visitors may counsel the mothers, model parent and-child interaction and may assist in developing contacts and referral to

other agencies where necessary. These training programs may increase positive reinforcement among family members improved communication, negotiation and problem-solving skills. Another aspect of this training programme may include teaching the children how to engage in a step-by-step approach to solve interpersonal problems. These may include teaching how to be less aggressive, impulsive, impatient and engage in fewer temper tantrums including exhibiting more concern for each other.

For late blooming delinquency, broad-based programmes may be needed that address the individual, peer group, family and community. Adolescents are counselled to learn how to resist negative peer pressure. Parents are also counseled to learn the importance of monitoring their children more closely. Communities need to take steps to provide definite consequences for youth misbehavior, but avoid labeling first time offenders as “delinquent”. Communities can also take steps to support and provide opportunities for youth to demonstrate their maturity in ways to benefit the society. The initial step in managing delinquency and juvenile crime is a thorough diagnosis of underlying causes by a professional counselor. At this point it should be borne in mind that therapy with the delinquents should be geared towards consideration of the delinquents total life adjustment. Such a consideration could bring significant and lasting changes in the delinquents’ personality patterns. Through this insight-oriented counseling the insight-oriented counselor listens to the youth’s concerns and problems and lead him or her to gain insight into the causes of these problems; this insight, in turn, is expected to lead the youth to discontinue delinquent behaviors. Sometimes the counselor also works with the youth to generate alternative solutions to the youth’s problems.

An important management strategy by counselors for juvenile crimes is the family therapy technique. In this technique, the child is allowed to express his/her feelings about the world. Then the parent and other members of the family are able to see

the child's world through the child's own perspective and picture the adolescent as a person striving for acceptance and individuality. As parents and family members begin to understand the adolescent's motivations and need the adolescent is struggling to meet, they can learn to help meet such needs in a more wholesome and acceptable manner. It is also counseled that counselors should evaluate the school adjustment, vocational opportunities and leisure time activities of the delinquents. On school adjustment, the delinquency could result from poor performance at school. Where the delinquency results from feelings of failure, the possibility of remedial study programme, securing a private tutor or checking on the adolescents' intellectual capacity may be considered. All these could lead the adolescent to an opportunity to experience success and accomplishment.

Delinquency may also result from vocational opportunities. In this case, the delinquency could result from the frustration of not feeling fulfilled or not being gainfully employed. A cursory observation shows that many adolescents, as a result of poor academic performances in secondary or lower education results become confused and unhappy and join gang to move with others like them to either while away their time or 'deadened' their feelings of failure. It may not be surprising, therefore, to find majority of these adolescents getting into deeper troubles and crimes on leisure-time activities, it may be observed that many delinquents are not engaged in wholesome recreations. It is, therefore, counseled that the counselor, therapist, parents or anyone interested in assisting the delinquent to change from delinquency to wholesome behavior may be able to help by providing wholesome recreation avenues for the delinquents. Youth's activities, volunteer jobs within the community for community development or religious activities based on ethical standards and norms maybe focused. Furthermore, successful individuals in various fields of work who are from the community

may be called upon to give talks on job placement and work experience. This may help the delinquents to learn more interpersonal skills which they may lack in relation to supervisors and co-workers. Their poor problem solving skills in such areas as work attire, transportation and punctuality may also be addressed along with money management skills. Competency development programs may be designed in various youth counseling centers in the communities. These programs features may include; assisting youth in setting specific and measurable goals, objectively diagnosing the youth's skill deficits and consecrating on providing the youth with necessary practical living, learning and working skills^{38,39,40}.

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Be Equipped Psychologically: The Psychological First Aid

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Keywords: *Psychological First Aid*

Many people who suffer from psychological and mental distress, personal crises and mental disorders can benefit from receiving psychological and mental health first aid from professionals and the general public.

One in four adults will experience mental health difficulties at one time or the other but many will receive little or no help when they present in an emergency. In contrast the majority of people with physical health difficulties who present in an emergency in a public or hospital setting will be offered physical health first aid.

Mental health crises and distress are viewed differently because of ignorance, poor knowledge, stigma and discrimination. This cannot continue to be allowed to happen, especially as we

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know that there can be no health without mental health. Psychological and mental health first aid should be available to all, and not just a few.

In the first few moments and hours after a disaster, survivors may have medical, material, social, and emotional needs. After the traditional steps to guarantee physical safety, it became common practice to also offer immediate psychosocial support. A contemporary definition of psychosocial support is given by the International Federation Reference Centre for Psychosocial Support of the Red Cross and Red Crescent Societies (2011) as “a process of facilitating resilience within individuals, families and communities”. This is based on the idea that people can rely on their own strengths to recover from the impact of a disaster or an adversity. Psychosocial support arose from the merger of social and psychological support. Social support lies at the heart of humanitarian aid organizations ever since their founding in the second half of the 19th century, fulfilling practical and social needs (e.g. reestablishing contacts with family members). Early psychological support following critical incidents was originally developed to support military personnel. After the recognition of posttraumatic as a psychiatric disorder in 1980, the idea to prevent psycho-trauma entered the work of humanitarian aid agencies from the beginning of the 1990s. However, on the field, trauma focused interventions proved to be ineffective and even harmful. Safer interventions were those that addressed the needs of the affected. Subsequently the idea of early psychological interventions merged with the social approach, leading to the concept of psychosocial support. A wide range of interventions were developed to provide psychosocial support. Today, one such intervention strategy is psychological first aid (PFA)

Psychological first aid (PFA) is a technique designed to reduce the occurrence of post-traumatic stress disorder. It was developed by the National Center for Post Traumatic Stress

Disorder (NC-PTSD), a section of the United States Department of Veterans Affairs, in 2006. It has been spread by the International Federation of Red Cross and Red Crescent Societies, Community Emergency Response Team (CERT), the American Psychological Association (APA) and many others.

To deliver psychological and mental health first aid properly, training is not enough. Training people in PFA improves their confidence in applying it. There is also the need for mental health promotion and good access to health providers. The world is going through a crisis. There are many disasters and wars, migration is a growing problem and many people require basic psychological and mental health first aid to prevent their health from deteriorating and to empower them to take action to improve their mental health.

Every 40 seconds somebody somewhere in the world dies by suicide, and the young are disproportionately affected. Providing more people with basic psychological and mental health first aid skills will help to decrease the rate of suicide.

Psychological and mental distress can happen anywhere - in our homes, in our schools, in the workplace, on the transport system, in the supermarket, in public spaces, in the military and in hospital. Psychological and mental health first aid is a potentially life-saving skill that we all need to have. Please support to make this a global reality so that we can make the world a better place *psychologically*.

History of Psychological First Aid

Before PFA, there was a procedure known as **debriefing**. It was intended to reduce the incidences of **post traumatic stress disorder** (PTSD) after a major disaster. Debriefing procedures were made a requirement after a disaster, with a desire to prevent people from developing PTSD. The idea behind it was to promote emotional processing by encouraging recollection of the event. Debriefing has origins with the military, where sessions were

intended to boost morale and reduce distress after a mission. Debriefing was done in a single session with seven stages: introduction, facts, thoughts and impressions, emotional reactions, normalization, planning for future, and disengagement.

Debriefing assumes that everyone reacts the same way to a trauma, and anyone who deviates from that path, is pathological. But there are many ways to cope with a trauma, especially so soon after it happens. PFA seems to address many of the issues in debriefing. It is not compulsory and can be done in multiple sessions and links those who need more help to services. It deals with practical issues which are often more pressing and create stress. It also improves self efficacy by letting people cope their own way. PFA has attempted to be culturally sensitive, but whether it is or not has not been shown. However, a drawback is the lack of empirical evidence. While it is based on research it is not proven by research. Like the debriefing method, it has become widely popular without testing.

Why Mental Health First Aid?

1. Mental health problems are common, especially depression, anxiety and misuse of alcohol or other drugs.
2. Many people are not well informed about how to recognize mental health problems, how to respond to the person, and what effective treatments are available.
3. There are many myths and misunderstandings about mental health problems.
4. Many people with mental health problems do not get adequate treatment or they delay getting treatment. There is stigma and discrimination associated with mental health problems.

The Concept of Psychological First Aid

“Psychological first aid involves humane, supportive and practical help to fellow human beings who have suffered a serious crisis event.”

MENTAL HEALTH FIRST AID IN SCHOOLS

Students with Disabilities or Other Impairments

- **Autism**

Children with an autism spectrum disorder (ASD), such as Asperger's Disorder, may be mainstreamed in general education classes or in self-contained classrooms depending on their disability and accompanying behavioral issues.

These students may be particularly sensitive to new people and to changes in their routine or surroundings. If possible, announce changes before they occur. These students may have heightened sensitivity to sounds, bright lights, new tastes, smells, or cold temperature that may disrupt their emotional equilibrium in response, for example, to sirens or alarm bells. Students with ASD may be obsessive or hyper-focused on some element of the crisis, and they may upset others when they perseverate on the details of an event or exhibit self-soothing behaviors such as rocking.

Many of these students have behavior plans that include their going to a predetermined "safe place" when they are distressed. When possible to do so, allow them to follow their behavior plans. They will respond best to a familiar teacher or other person in authority who can calmly reassure them of their safety and set firm limits on their behaviors. For students in a self-contained classroom, the most helpful intervention will be a return to their normal daily routine. They may not be responsive to new people. For many of these students, attempts to teach them exercises meant to help them cope may, in fact, increase their distress.

- **Learning Disabilities**

Children with one or more learning disabilities (such as dyslexia, visual/spatial problems, expressive or receptive language disorders, memory deficits) tend to be in general education classes.

These children should be responsive to most PFA-S strategies. The nature of the learning disability may affect a child's ability to benefit from a specific exercise. For example, a student with a language disability may have difficulty expressing his/her feelings in writing, or he/she may have difficulty accurately recalling contact information such as a phone number and street address. Adapt specific exercises to the student's strengths.

- **Speech Impairment**

Children with speech and language deficits, including students with language processing issues, tend to be in general education classes.

Students with language deficits may have difficulties with comprehension or with verbal expression. These students may respond best to exercises that include activities and visual cues, such as artwork, or relaxation strategies that can be modeled rather than just described.

- **Cognitive Impairment**

Students with mental retardation/cognitive delays may be mainstreamed in general education classes or in self-contained classrooms, depending on the severity of their disability and accompanying behavioral issues.

Similar to students with autism, students with cognitive delays will do best after they return to their normal routine. Higher functioning students in general education classes may require simpler, more concrete directions, but they should respond to most PFA-S strategies.

- **Emotional Disturbance**

Children identified as having an emotional impairment may have a variety of mood (depression, anxiety, anger, fear, apathy) and/or behavioral (aggression, withdrawal, hyperactivity, temper tantrums) issues, with the most serious disturbances including distorted thinking, excessive anxiety, bizarre motor

acts, abnormal mood swings, or psychosis. Some of these students will have a trauma history, and the current event may bring up reminders of past events that will be unsettling and disruptive. These students, whether mainstreamed in the general population or in self-contained classrooms, may act unpredictably and need their teachers and support staff to intervene.

While most children with an emotional disturbance status may be responsive to the PFA-S techniques you are using, ask their teachers to identify which students may be resistant or become distressed. Most of these children will have behavioral intervention plans that include options for them to follow in certain circumstances; for example, a child who may become out of control is allowed to visit a particular adult or engage in a particular activity in order to self-soothe. When possible, try to follow the familiar and established routine. If this is not feasible, the child's teacher, aide, or another familiar member of the child's team should be the one to explain the new plan to him/her.

- **Attention-Deficit/Hyperactivity Disorder (ADHD)**

In a crisis, you may see students with ADHD increase their symptoms of hyperactivity and impulsivity, resulting in out of control behavior.

Students with ADHD will benefit from activities that allow for physical movement. When giving directions, calmly tell students exactly what you expect, avoid directions with more than one or two steps, and give warnings about specific consequences for inappropriate behavior.

MENTAL HEALTH FIRST AID IN GENERAL SETTINGS

Why everyone needs to have mental health first aid skills

- Mental health problems are common; with one in four people worldwide experiencing mental health problems, but lack of knowledge and the associated stigma may prevent people from seeking appropriate help at an early stage.

- Family, friends, neighbors and colleagues can assist by offering help to someone when they notice the signs and symptoms of a mental health problem. Where an issue is identified early on it is more likely that a mental health crisis may be avoided.
- Mental health first aid skills can be learned by anyone and should be considered as important as physical first aid because if someone sprains their ankle the chances are you will know what to do. If they have a panic attack, the chances are you won't. However, mental health first aid doesn't teach you to be a psychiatrist or counselor. A mental health first aider's role is to support and guide a person to seek appropriate professional help.

How do I know if someone is experiencing mental health problems?

- Only a trained professional can diagnose someone with a mental illness but those who have attended an MHFA course will be able to spot the signs and symptoms of a range of mental health problems, including anxiety, depression and psychosis.
- If you notice changes in a person's mood, their behaviour, energy, habits or personality, you should consider a mental health issue as being a possible reason for these changes.
- Remain aware that each individual is different and not everyone experiencing mental health problems will show the typical signs and symptoms but it's important to feel able to open up a conversation if you are concerned about someone's mental health.

How should I approach someone who I think might be experiencing mental health problems?

- Give the person opportunities to talk. It can be helpful to let the person choose when to open up. However, if they do not

initiate conversation about how they are feeling it is important that you speak openly and honestly about your concerns

- Choose a suitable time to talk in a space you both feel comfortable where there will be no interruptions
- Use 'I' statements such as 'I have noticed....and feel concerned' rather than 'you' statements
- Let the person know you are concerned about them and are willing to help
- Respect how the person interprets their symptoms
- If the person doesn't feel comfortable talking to you, encourage them to discuss how they are feeling with someone else.

PFA is a multifactorial intervention based on five key principles as outlined by Hobfoll et al. PFA interventions therefore can take on many different forms depending on the contexts and cultures in which disasters or adversities occur. Each of these interventions should be evaluated separately in experimental studies to gain knowledge on their effectiveness. Finally, in the domain of behavioral sciences, resistance by certain professionals towards evidence-based practice and a lack of uniform definitions and terminology, might contribute to the lack of evidence. A negative attitude about evidence and evidence-based practice can be due to a lack of training and misconceptions regarding the concept of evidence-based practice.

Although PFA is considered to be an important approach for disaster-affected populations, there is a complete lack of high-quality experimental and observational studies on the effectiveness of PFA in the immediate aftermath of a disaster. Consequently, research is needed to determine the most effective, efficient, and acceptable interventions before evidence-based PFA guidelines on how to train laypeople and professionals can be developed.

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Study of Domestic Violence in Female Patients of Schizophrenia

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ABSTRACT

Background - Schizophrenia is a chronic illness which puts burden on the patient and caregivers. Behavioral problems in Schizophrenia lead to domestic violence especially on females in India. **Aim** - To study the co-relation between level of psychopathology in Schizophrenia and domestic violence and also between domestic violence and anxiety or depression. **Materials and Methods** – 30 female patients diagnosed with Schizophrenia (as per ICD 10) were recruited from OPD at Psychiatric Center, Jaipur. The Positive and Negative Symptom Scale, Interview Schedule for Violence in Women (Hindi version), Hamilton Rating Scale for Depression and Hamilton Rating Scale for Anxiety were applied. SPSS 20 was used for statistical analysis. Results and **Conclusion** - The total score of Domestic Violence was not found to be significantly associated with psychopathology in Schizophrenia. Domestic Violence was found to be significantly associated with Anxiety and Depression

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($p < 0.05$). This emphasizes the need to undertake measures to prevent domestic violence and thus prevent anxiety and depression in patients of Schizophrenia, for an improvement in the overall outcome of treatment.

Keywords: *Domestic Violence, Female Patients of Schizophrenia*

Domestic violence is defined as ‘any incident of threatening behavior, violence or abuse (physical, psychological, sexual, emotional or economical) between adults who are or have been intimate partners or family members, regardless of gender or sexuality’ (11). This definition encompasses traditional cultural practices, including forced marriage, honor-killings and female genital mutilation in addition to partner violence. However, there is no international consensus on which term to use for domestic violence and some believe that the term ‘domestic violence’ is misleading because domestic implies that the violence is occurring at home. Some international studies use the term ‘intimate partner violence’ but it implies an intimacy that partners may not share and assumes violence from the partner when in fact other family members may be involved (2). In this article the term ‘domestic violence’ has been used with reference to violence from spouse. In general population, the lifetime prevalence of domestic violence is comparable for men (one in five) and women (one in four), but women are at a greater risk for repeated coercive, sexual or severe physical violence (12). The WHO multi-country study reported a lifetime prevalence of physical and/or sexual partner violence between 15 and 71 % in women. A systematic review by Alhabib reported highest mean lifetime prevalence rates for physical and sexual violence in healthcare settings, including psychiatric settings (1). Lifetime prevalence of severe violence amongst psychiatric inpatients is 30-60% (13). Domestic violence is more hidden and potentially more psychologically harmful than stranger violence because of the nature of the

relationship between the perpetrator and the victim (4). There is ample evidence supporting a causal relation between domestic violence and psychiatric disorders in both directions (10). Pre-existing mental health problem influences the vulnerability to domestic violence by increasing the likelihood of being in unsafe environments or relationships (19). The cultural influences in our country also contribute to domestic violence by making caregivers believe that they have a right over the victims and need to teach them a lesson for their inappropriate behavior. This constitutes a part of 'expressed emotions' by relatives in the form of hostility towards patients, due to difficulty faced by them in regulating emotions. The lack of effective enforcement of laws prohibiting domestic violence has further provided impetus to a general lack of respect for the patients with Schizophrenia and thus to their victimization. Domestic violence has deleterious effects beyond trauma and is associated with many mental health consequences, including post traumatic stress disorder (PTSD), depression, substance misuse, functional symptoms and exacerbation of psychotic symptoms (12). In fact, psychological violence can be as detrimental to mental health as physical violence (18). Except for prevalence and observational studies conducted in recent years on population in Varanasi, Rohtak and Mumbai, there is limited literature pertaining to co-relation or intervention studies on this issue from Indian setting. The current study aimed at exploring domestic violence among patients with Schizophrenia. It aimed to explore the correlation between the level of psychopathology in Schizophrenia and domestic violence in those patients. Also, it aimed to find the correlation between domestic violence and anxiety and depression among patients with Schizophrenia.

MATERIALS AND METHOD

The current study was carried out in the out-patient psychiatry department of a tertiary care treatment centre. A cross-

sectional observational design was used to study a sample of 30 female patients diagnosed with Schizophrenia as per ICD-10 (17). Those willing to participate in the study and giving informed consent were included in the study. The study subjects were assessed using semi structured proforma to collect socio-demographic details and illness related details; Positive and Negative Symptom Scale for Schizophrenia (PANSS); Interview Schedule on Violence against Women (ISVW)- Hindi version; Hamilton Rating scale for Depression (HAM-D); and Hamilton Rating scale for Anxiety (HAM- A). PANSS is an objective scale which gives separate scores on domains of positive, negative and general symptoms. In order to make sure that psychopathology was not directly contributing to the symptoms of anxiety and depression, the patients with scores above 25 on positive and negative scales and above 35 on general symptoms scale, were excluded (24). ISVW- Hindi version is a scale devised after unanimous opinion of a team of experts working in the field of research in this area, after applying it on two successive occasions on a group of 50 females, at an interval of two weeks (Reliability = 0.85). The scale was originally comprised of 50 questions which were selectively condensed to a set of 20 questions answered on a score of 0 to 2 (total score 40). A score of >5 is considered as positive and further graded as mild, moderate or severe. Domestic violence over the past one year was assessed. Hamilton Rating scale for Depression is an objective assessment of the level of depression. Hamilton Rating scale for Anxiety is an objective grading of severity of anxiety symptoms. The HAM-A and HAM-D were used to assess symptoms of anxiety and depression, respectively over the past 6 months. The subjects with insight score of less than/ equal to three (as assessed by PANSS) and Domestic Violence score of more than five were included in the study. Data were analyzed using SPSS version 20. Descriptive analysis was carried out for the study variables where the mean values and standard deviation for scores on each variable were

calculated. Co-relation between domestic violence and Schizophrenia as well as between domestic violence and anxiety and depression was analyzed using the Pearson's co-relation coefficient. The level of statistical significance was kept at $p < 0.05$.

RESULTS

It was found that more than three-fourth of the cases belonged to an age of > 30 years (mean = $34.87 \pm$ write SD as well years). About a third of cases were graduates and more than a third had passed higher secondary education. Very few cases (13.33%) were illiterate. Around 40 % of the women were employed outside their homes and the rest were homemakers. With respect to the distribution as per the type of family, half of the women belonged to joint families while the rest belonged to nuclear or nuclear extended families. The mean duration of illness of the study subjects was $4.75 \pm$ years. About two-third of the subjects had a history of illness in the range of 3-6 years. The descriptive analysis for the variables on the PANSS, HAM-A, HAM-D and ISVW has been presented in table 1.

Table 1: Psychopathology, anxiety, depression and experience of domestic violence scores for the study subjects (N=30)

Variables	Mean	SD
PANSS		
Positive	18.25	7.77
Negative	14.75	3.73
Composite	3.5	5.68
General	22.65	8.76
HAM-A	12.125	4.086
HAM-D	10	2.5
ISVW- Hindi version		
Domestic Violence	8.5	1.77
Physical	0.75	0.70

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Sexual	0.125	0.35
Emotional	3.25	1.16
Economical	0.5	0.755
Social	3.875	1.12

A positive co-relation was found to exist between psychopathology and domestic violence. A negative co-relation was found between psychopathology in Schizophrenia and sexual violence. However, none of the values reached level of statistical significance (Table 2). There was a positive co-relation between violence and the severity of anxiety (0.799, $p = 0.017$). Economical and social violence also had positive co-relation with anxiety scores but failed to reach statistical significance ($p = 0.06$). A positive co-relation was found between total score of Domestic Violence and depression scores (0.804, $p = 0.016$). Economical violence showed a positive co-relation with depression scores but did not reach statistical significance ($p = 0.06$).

Table 2: Significant correlation between various study variables (N=30)

Variables	Coefficient of correlation	<i>p value</i>
Psychopathology and domestic violence	0.804	<i>0.016</i>
Depression and domestic violence	0.799	<i>0.017</i>

DISCUSSION

The Dunedin Multidisciplinary Health and Development Study in New Zealand found that intimate partner violence was associated with an increased risk of psychiatric disorders among women and there was a past history of substance misuse and other

psychiatric illnesses in women of this group, highlighting the bidirectional causality among the two (6). In line with this view, it has been reported that mental health disorders like schizophrenia appear to elevate the risk of victimization in domestic violence (8). The results in our study are in keeping with the possibility of such relationship between schizophrenia and violence experienced by women. However, the severity of underlying schizophrenia did not appear to influence the severity of resultant violence significantly. There is a dearth of studies to further corroborate this finding.

An Indian study on Hinduism, marriage and mental health quotes that the most vulnerable group for domestic violence seems to be of the women who were married off at an early age by parents who no longer wanted to take responsibility for them or were concerned about their ineligibility as wives. These stigmatized attitudes tend to continue after marriage and contribute to reinforcing their sense of vulnerability and social burden (28). A study by the Schizophrenia Research Foundation (SCARF) showed that mental health problems in women were given low priority as compared to males in terms of latency and frequency of consultation (29). Married women with Schizophrenia especially form a high risk population for various forms of abuse where the victims are unable to raise their voice against violence or protect themselves. Such women are more likely to be victims than perpetrators of violence (16, 26). In the current study all subjects were married and were symptomatic at the time of interview. With the focus of study on violence by spouse, the observations from the above research are reflected in this study in terms of marital status of the women, their home environment and spousal attitude towards their illness, causing hostility and inadequate care.

Researchers have observed over the years that when a woman presents with depression, anxiety, insomnia, suicidal

ideation or post traumatic stress disorder, it is very likely that she has underlying abuse and violence issues (15).

It appears that a vast majority of people with severe mental illnesses like schizophrenia have experienced physical or sexual assault during their lifetime and often have a history of childhood sexual abuse (14). It is found that sexual trauma experienced by a patient leads to a form of schizophrenia with severe anxiety, heightened hallucinations and social withdrawal. Such patients are all the more likely to be preyed upon (22). Thus, sexual violence is a hidden culprit amongst patients who have a worse form of underlying Schizophrenia and leads to further degradation of the illness. Contrary to the above findings, our study found a negative correlation between sexual violence and severity of illness. This suggests a probable under-reporting of sexual violence in the conservative Indian scenario or perhaps points towards various barriers to disclosure of information pertaining to such a sensitive matter. Research has shown that women may not disclose unless they are asked (7, 27). It has been found in extensive research by Howard that domestic violence in mental health services is under-detected internationally with only 10-30 % of recent violence asked about and disclosed in clinical settings (13). Factors like the fear of consequences, shame, public involvement, child protection proceedings, fear of not being believed, presence of the perpetrator when being interviewed and fear that disclosing would lead to further violence impede the disclosure (27). The lack of knowledge, expertise or responsibility on the part of mental health professionals, other than barriers related to gender or cultural issues add to the patient concealing the history of abuse. The disclosure of this sensitive matter can essentially be facilitated by good communication skills regardless of gender and by empathic listening, emotional validation, promising confidentiality and a non-judgmental attitude (9). Studies on the association between domestic violence and mental health indicate that experience with violence is associated with

adverse mental health effects (3, 21). Amongst them, depression and anxiety account for most of the burden (31). While examining the temporal relationship between violence and depression, Karen et al found that among women, symptoms of resultant depression were associated with intimate partner violence. Domestic violence increases the odds of depressive symptoms and suicide attempts among women (5). National Survey of Families and Households, USA suggested that women experiencing domestic violence are more likely to show depressive symptoms at 5 year follow up (33). To assess the proportion of mental health disorder attributable to exposure to domestic violence based on an assumption of causality, PAF (population attributable fraction) of violence on depression in pregnant women was calculated by Ludermir in a Brazilian population and accordingly, post-natal depression in women was estimated to be 10% (23).

The significant association of domestic violence with both anxiety and depression found in our study replicates the above findings. This association also replicates the data from a systematic review which found that severity and duration of violence was associated with prevalence or severity of depression and declined over time once the abuse had ceased (15).

With respect to symptoms of anxiety, self report of trauma, especially sexual trauma is linked to particularly high levels of anxiety amongst patients of Schizophrenia (22). This association of sexual trauma with anxiety could not be replicated in our study for aforementioned probable reasons.

Evidence shows that depression increases odds of further violence. And severe levels of anxiety further worsen Schizophrenia in the form of more hallucinations, poorer functioning and hopelessness (22). This highlights the need to stop the vicious cycle between domestic violence and psychiatric disorders, both affecting each other adversely. An important step in this direction would be to effectively detect and control domestic violence in patients and also treat co-morbid psychiatric

symptoms. Introduction of routine enquiry for domestic violence while treating patients can help early detection of the same and curb further damage to the mental health of victims, although the practical efficacy of this method has not yet been demonstrated in studies. Ludermir demonstrated that reducing the prevalence of domestic violence in our society could substantially reduce the burden of mental disorders and the costs to health services (23). In addition to effective pharmacological management of underlying schizophrenia, psychological interventions also play an important role in global care of these women. A review by Feder found psycho-education on feminist self-empowerment strategies and self-advocacy modules to have modest benefit in reducing depressive symptoms and improving self esteem in the victims of domestic violence. However, it is difficult to extrapolate these results to women with severe psychiatric illnesses (7). Experts suggest safety based interventions by para-professionals or cognitive-behavior therapy delivered by psychologists to have promising results in improving depression in these patients (25, 7). A study exploring relationship between mental health and domestic violence conducted in Indian sub-continent in Pakistan concluded that violence in the form of adverse life events and verbal aggression increased vulnerability to further mental health problems and suicidal ideation. They found proper psycho-education and social support to be protective on this down-hill road. In clinical relevance, there is need to address mental health issues and risk of suicide in victims of domestic violence, in addition to stopping the violence effectively (20). This includes the need to make social and health care policies pertaining to severity of violence inflicted upon a mentally ill patient more stringent. Currently, the PWDVA (Protection of Women from Domestic Violence Act) in India provides for effective protection of rights of women who are victims of violence of any kind in a domestic relationship, guaranteed under the Constitution. It takes a conciliatory approach and empowers women to file a criminal

law suit if required (30). New guidelines from World Health Organization recommend partnership of primary care workers and mental health service workers with the domestic violence sector in addressing the needs of patients (32).

The current study has certain limitations. The sample size of the study was very small due to stringent inclusion criteria and probable barriers to disclosure of violence. Retrospective assessments could have introduced recall bias. Inclusion of a control group would have strengthened the results of the study. Active psychopathology in the patients could lead them to give biased or exaggerated responses while assessing domestic violence. However, an attempt was made to overcome this factor by including patients with reasonable insight. In conclusion, domestic violence is strongly associated with psychiatric disorders like Schizophrenia, but the level of psychopathology does not seem to significantly influence the severity of violence. Domestic violence is associated with anxiety and depression in patients of schizophrenia and thus can worsen the course of the illness. There is need to undertake appropriate measures to prevent domestic violence in Schizophrenia, for an improvement in the overall outcome of treatment.

RECOMMENDATIONS FOR CONTROLLING VIOLENCE AGAINST WOMEN

Mental illness Psychiatric illness should be identified and treated promptly. Patients with active symptoms should be kept in a protected environment till substantial improvement takes place. Many patients may need life-long protection e.g. those suffering from mental retardation or chronic schizophrenia. Women with severe mental illness need special attention. Public awareness needs to be created with respect to the following: • Women need protection but those with mental illness need more care and protection. • The real problem is not mental illness, but the negative attitude toward it. • Many medical illnesses create more

problems in marriage, than mental illnesses. • There should no double standard? If a woman can continue the marriage after her husband develops a mental illness, so can the husband. Similarly, people should be made to understand that if it is right to marry a son or daughter with mental illness, then the reverse is also true. A daughter in-law with mental illness should also be accepted. • Good family support greatly improves the prognosis. • Many women with mental illness prove to be better marriage partners and daughter-in-laws than those without mental illness. • If the husband's family accepts the woman with mental illness, the society will also follow • Woman with mental illness should be accepted with her illness. • Violence is not the solution. Mental illness in the victim (e.g. depression) or perpetrator (e.g. alcoholism or schizophrenia) should be promptly treated.

Restriction on use of alcohol-There should be prohibition of alcohol use in mass gatherings in institutions, public places like trains and buses. The number of alcohol outlets should be decreased. The age for purchasing alcohol may be raised to 30 years. Special checks on festive occasions are recommended with the help of breath analyzers. Involuntary treatment of persons with alcohol dependence should be carried out.

Control on media Sexual material should be censored. Good themes, which condemn violence and glorify rehabilitation of the victim, should be projected. Ban on pornography should be strictly implemented. The sites may be blocked.

Marriages Marriage of boys and girls should preferably be in early 20s, as soon as feasible, so that sexual needs could be satisfied in a socially appropriate manner.

Strengthening the institution of marriage Strong marital bond would act as a deterrent. The “Shiv-Parvati” model should be promoted for Hindus.

Law enforcement Efficient and accountable law enforcement machinery at all levels (administration, government, police and judiciary) is needed.

Legislation Change in mind set of the judiciary- This is the need of the day. Indira Jaising, Additional Solicitor General of India, aptly stated “It’s time for India’s courts to gaze inward and throw out deeply embedded patriarchal notions that stop judgments from being fair to women. Sexism within the system has to go before it does more damage in the country.”[34] A High Court judge in Orissa in his judgment once famously held “It was not possible for a man, acting alone, to rape a woman in good health.”[34]

Amendments in existing legislations The Hindu Marriage Act (1955):[35] Mental illness may be removed from conditions of Hindu marriage. Not informing about past illness of mental illness should not be a ground for nullity of marriage. PWDVA, 2005 and DPA, 1961: Assessment for mental illness may be incorporated in the code civil procedure so that the mental illness is identified in the victim (woman) and/or perpetrator (male relative) and promptly treated. This way violence can be prevented.

New legislations New legislation is needed to provide for granting “Interim Relief” (A big sum of money that is paid by the perpetrator) to a victim of severe sexual assault. The money may be utilized for rehabilitation of the victim. Rehabilitation of the victims of brutal sexual assaults should be the State’s responsibility. The legislation should provide for enhanced punishment for violence perpetrated against women with mental illness

Appropriate application of laws in the setting of mental illness This is often very difficult, nevertheless very important. Judiciary handling such cases should desirably have both legal (LLB) as well as medical (MD Psychiatry/DPM) qualifications.

Code of conduct Code of conduct at work place, school and home, with respect to interaction with persons of opposite sex should be outlined and implemented.

Gender sensitization Gender sensitization by parents and teachers is needed regarding the sensitivities and boundaries of man-woman relationships.

Education and employment Improvement in quality of education and employment opportunities for youth.

Recreation and talent Recreational avenues and opportunities for talent development in young people.

Moral and religious values Parents and teachers should strive to infuse good moral and religious values in children and serve as role models.

Population control Last, but not the least, If we are sincere we will get the results. Let us all say “No” to violence against women.

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Mindfulness for Positive Mental Health

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ABSTRACT

The practice of mindfulness is increasingly being integrated into contemporary clinical psychology. Based in Buddhist philosophy and subsequently integrated into Western health care in the contexts of psychotherapy and stress management, mindfulness meditation is evolving as a systematic clinical intervention. This paper describes of mindfulness meditation predominantly in medical settings, as originally conceived and developed by Kabat-Zinn and colleagues. Given the extensive evidence base for the efficacy of mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT), researchers have started to explore the mechanisms underlying their therapeutic effects on psychological outcomes, using methods of mediation analysis. The present paper aims to systematically review mediation studies in the literature on mindfulness-based interventions (MBIs), to identify potential psychological mechanisms underlying MBCT and MBSR's effects on psychological functioning and wellbeing, and evaluate the strength and consistency of evidence for each mechanism.

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Keywords: *Mindfulness, Mediation, Mental Health, Psychotherapy, Intervention*

Many diverse religious traditions in the world have given rise to a rich variety of meditation techniques and practices, which have been practiced for millennia. These meditation practices have reflected the wisdoms, insights, inclinations, and cultures of their practitioners. Originally, they were intended to develop spiritual understanding, awareness, and direct experience of ultimate reality. The last four decades have witnessed a sharp attention and interest in meditation-based approaches to treating individuals with physical and mental health problems in the West.

Defining Mindfulness

From scientific point of view mindfulness is not an easy concept to define. Jon Kabat-Zinn (1994) defines mindfulness as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally". Mindfulness is a highly alert and skillful state of mind because it requires one to remain psychologically present and 'with' whatever happens in and around one without adding to or subtracting from it in any way. All that exists during the state of mindfulness is 'this' moment. Mindfulness is not a process of analysis but being simply aware of experiences, which are taking place at 'this' moment. By analyzing own experiences one either lives in the past or projects into the future. Mindfulness is about being "here and now". Mindfulness is an attribute of consciousness which is also known as 'awareness' or 'witnessing' or '*Sakshi Bhava*' in Sanskrit.

Mindfulness is being attentive to the sensory information entering mind through five senses. Langer has defined mindfulness as "a state of conscious awareness characterized by active distinction drawing that leaves the individual open to novelty and sensitive to both context and perspective. In contrast,

mindlessness has been conceptualized as a state of mind characterized by an over reliance on past categories and distinctions whereby the individual is context-dependent and oblivious to novel (alternative) aspects of situations.

Brown and Ryan (2003) define mindfulness as “a receptive attention to and awareness of present events and experiences”

Bishop et al. (2004) describes mindfulness interventions in the following way: The clientattempts to maintain attention on a particular focus, most commonly the somatic sensations of breathing...whenever attention wanders from the breath to inevitable thoughts and feelings that arise, the client will simply take notice of them and let them go, as attention is returned to the breath....in a state of mindfulness, thoughts and feelings are observed as events in the mind, without over-identifying with them and without reacting to them in an automatic, habitual pattern of reactivity. This dispassionate state of self-observation is thought to introduce a space between one's perception and response....thus mindfulness is thought to enable one to respond to situations more reflectively (as opposed to reflexively)

Mindfulness: A Deeper Understanding

Mindfulness is a mental discipline involving training attention. It is not a method of distracting ourselves or tuning out, it is about tuning in –hence people perform better when mindful (in the zone/flow). The anxious, stressed or depressed state of mind is the distracted state.

Mindfulness has been the subject of growing attention and interest in recent years, thanks to a rapidly expanding evidence base demonstrating that it can be helpful for many mental and physical health problems, as well as for improving well-being more generally. Mindfulness is an integrative, mind-body based approach that helps people change the way they think and feel about their experiences, especially stressful experiences. It

involves paying attention to our thoughts and feelings so we become more aware of them, less enmeshed in them, and better able to manage them. Mindfulness interventions are often seen as situated within the cognitive behavioural tradition. However, they also have their roots in the ancient practice of meditation. They differ from traditional cognitive behavioural therapies in that they do not encourage people to challenge their thoughts, and they are not goal-directed. Rather, Mindfulness interventions aim to teach us how to accept our thoughts without unhelpfully identifying with them. When people practise Mindfulness, they are encouraged not to aim for a particular result but simply to “do it, and see what happens”. The first Mindfulness-based Stress Reduction (MBSR) programme, developed in the US, has inspired a number of variations, including Mindfulness-based Cognitive Therapy (MBCT); Acceptance and Commitment Therapy (ACT), a Mindfulness-based Psychotherapy; and Dialectical Behaviour Therapy (DBT), a Cognitive Behavioural and Mindfulness-based Therapy for borderline personality disorder.

Mindfulness meditation involves expansion of the attention or awareness to become aware of the ongoing of sensations and feelings, images, thoughts, sounds, smells, and so forth without becoming involved in thinking about them. Mindfulness meditation can be likened to a wide-angle lens be aware of the entire field. In integrated meditation a shifting back and forth of attention occurs.

Mechanisms Underlying Mindfulness-Based Interventions

One of the most systematic and intricately laid out Eastern psychologies is classical Buddhism, known as *Abhidhamma* in the Pali. The *Abhidhamma* or *Abhidharma* (in Sanskrit) means “the ultimate doctrine” elaborates original insights of Gautama the Buddha (536-438 B.C.) into human nature. As a prototype of Asian psychology *Abhidhamma* presents us with a set of concepts

for understanding the working of mind. Vipassana or mindfulness meditation is one of the India's most ancient meditative techniques and its nature and description can be seen in the texts of *Vigyan Bhairav Tantra* and *Ashtavakra Samhita*. It was rediscovered by Gautama the Buddha. Vipassana meditation has its origin in Theravada and Mahayana Buddhism. Vipassana in Pali means insight. To see things as they really are, in their true perspective, in their true nature. The word *Vipassana* is combination of two words *Vi* and *Passana*. *Vi* means "in a special way" and *Passa* means to see, to observe. Hence *Vipassana* means, "observing in a special way". There are four other concepts relevant to *Vipassana* namely *Sati* (mindfulness), *Samadhi* (absorption), *Panna* or wisdom, and *Bhavana* (meditation including *Sati*, *Samadhi* and *Panna*). Vipassana meditation is also known as insight or awareness or mindfulness meditation. Mindfulness is the English translation of Pali word *Sati* and synonymous to being conscious or aware, taking heed, taking note of, observing, and paying attention.

The Buddhist text *Maha-Satipattana Sutta* (The Great Discourse on the Establishing of Awareness) deals with the technique of Vipassana meditation in detail. It describes and discusses four foundations of mindfulness in terms of four *satipatthanas*:

1. *Kayanupassana satipatthana* (awareness of body parts and functions such as breathing),
2. *Vedananupassana satipatthana* (awareness of sensations),
3. *Cittananupassana satipatthana* (awareness of mind, thoughts), and
4. *Dhammananupassana satipatthana* (awareness of mental contents and hindrances).

The process of drawing novel distinctions during mindfulness state can lead to a number of diverse consequences, including (i) a greater sensitivity to one's environment, (ii) more

openness to new information, (iii) the creation of new categories for structuring perception, and (iv) enhanced awareness of multiple perspectives in problem solving. The phenomenon of mindfulness also has implications for the ways in which we view and represent the mind and its connection to the brain.

Some elements of the mindfulness include appreciation and attention. It is the centrality of this awareness that has transforming and transcending capabilities and unifies the rational and holistic aspects of mental functioning. It is also important to remember that mindfulness is not about trying to make life more enjoyable. Although as a result of it your life might become more enjoyable, “mindfulness is more about experiencing what you are experiencing. If you are experiencing discomfort or pain you can be mindful of that too. In fact, when you place your attention on the discomfort you will find that it loses its impact and you will feel more in control”.

Applications of mindfulness

A growing body of robust evidence from randomised controlled trials (RCTs) has demonstrated that MBIs are effective in improving a range of clinical and non-clinical psychological outcomes in comparison to control conditions, including anxiety (Green & Bieling, 2012; Hofmann, Sawyer, Witt, & Oh, 2010), risk of relapse for depression (Kuyken et al., 2008; Teasdale et al., 2000), current depressive symptoms (Strauss, Cavanagh, Oliver, & Pettman, 2014), stress (Chiesa & Serretti, 2009), chronic pain (Grossman, Tiefenthaler-Gilmer, Raysz, & Kesper, 2007), quality of life (Godfrin & Heeringen, 2010; Kuyken et al., 2008), psychological symptoms in patients with cancer (Ledesma & Kumano, 2009) and retrieval of specific autobiographical memories (Williams, Teasdale, Segal, & Soulsby, 2000), a reliable cognitive marker of depression (e.g. Brittlebank, Scott, Williams, & Ferrier, 1993). Other notable interventions which involve mindfulness principles alongside other components

include acceptance and commitment therapy (ACT; Hayes & Wilson, 1994) and dialectical behavioural therapy (DBT; Linehan, 1993).

- Mental health: E.g. depression relapse prevention, anxiety, panic disorder, stress, emotional regulation
- Neuroscience: E.g. structural and functional changes in the brain, neurogenesis, dementia prevention
- Clinical: E.g. pain management, symptom control, cancer, metabolic, hormonal
- Performance : E.g. sport, academic

12 Mindfulness-based therapies

- Stress
- Anxiety
- Depression
- Eating disorders
- Panic disorder
- Symptom control
- Coping
- Chronic pain
- Personality disorder
- OCD
- Neural plasticity
- Immune modulation
- Anti-inflammatory
- Enhancing immune function
- Behaviour / lifestyle change
- Improvements in sleep
- Rumination
- General wellbeing
- Cellular ageing

Kazdin (2007) emphasises several clinically relevant reasons why establishing the mechanisms of psychotherapies is crucial. Kabat-Zinn observes that mindfulness is a universal human faculty that is recognized in all cultures of the world for its intrinsic and transformative qualities. It is not limited by cultural boundaries and has acquired a fundamental place in behavioral medicine, which explicitly recognizes the interconnection of body and mind in its scientific understanding of disease and health. Therefore, different meditation practices are taught independent of the religious and cultural beliefs associated with them. Mindfulness can: i) stimulate one's body's mechanisms of regeneration through a direct effect on neuro-physiological, hormonal and immune responses, ii) decrease the intensity of, and sometimes eliminate physical and psychological symptoms, ranging from anxiety and high blood pressure to various types of physical pain, iii) positively modify the course of illnesses, leading to an improved prognosis and lifestyle, or at times remissions, iv) decrease the likelihood of a relapse after a depressive episode, v) increase energy levels and the ability to relax, vi) free-up one's creative potential as the world takes on a more nurturing quality, and vii) create a sense of one's life being more meaningful.

Mindfulness over the last two decades have proven to be effective in the subjects of clinical as well as subjects of non-clinical population who experience symptoms of stress, psychological disorder or stress related medical condition. It also enhances well-being by improving the coping skills of the individual and modifying the way in which a person perceives the stress. The clinical and other studies on mindfulness meditation and the Mindfulness-Based Stress reduction (MBSR) developed by Kabat-Zinn at the University of Massachusetts show its effectiveness in chronic pain, chronic disease, cancer, fibromyalgia, psoriasis, stress reduction, anxiety and depression. Research has shown that the majority of people who went through

Vipassana or mindfulness based treatment programs report lasting reductions in both physical and psychological symptoms. Their attitude and behavior undergo deep, positive changes that are rooted in a less conflicted perception of self, others and the world. This results in an increased ability to cope effectively with both short-term and long-term stressful situations. Therefore, mindfulness meditation and therapeutic programs based upon its basic assumptions and practices can be used effectively in the treatment of a wide range of mental and physical health problems.

Today when we look back, Buddha not only evolved a new technique of meditation the mindfulness but also recommended that meditation must be essential part of life as a continuous process. Buddha gave a totally new vision of meditation to the world, before Buddha meditation was something that you had to do once or twice a day. Buddha gave a totally new interpretation to the whole process of meditation. Meditation cannot be something that you can do apart from life just for an hour or fifteen minutes. Meditation has to become something synonymous with our life; it has to become like taking breathing. It should become such a constant phenomenon, only then it can transform us and lead to conscious living.

Mindfulness is a mental state characterized by nonjudgmental awareness of the present moment experience while encouraging openness, curiosity, and acceptance. This skill can be learned through practice, and has been integrated in different clinical approaches. Mindfulness-Based Stress Reduction (MBSR) is a structured group programme conceived to alleviate suffering associated with physical, psychosomatic and psychiatric disorders. A systematic review of RCTs on MBSR supports that this approach improves mental health in non-clinical and clinical populations. In clinical populations with psychiatric disorders, MBSR has some benefit as it reduces symptoms of distress, anxiety and depression or teaches patients coping skills to handle these symptoms. Mindfulness-Based Cognitive Therapy (MBCT),

which is an adaptation of the MBSR programme, incorporates elements of cognitive therapy to prevent depressive relapse. Meta-analysis indicate that MBCT is an effective intervention for relapse prevention in patients with recurrent major depressive disorder in remission, at least in case of three or more previous episodes. Moreover, in two studies, MBCT was at least as effective as maintenance antidepressant medication. While MBCT is a relapse prevention programme for patients in full remission, recent data suggest that it may be indicated also for people in partial remission, including those with quite significant residual depressive symptoms.

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Sex-Education & Counseling: Effective Prevention & Management Tools for HIV/AIDS

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ABSTRACT

Just as schools are critical settings for preparing students academically, they are also vital partners in helping young people take responsibility for their own health.

Control of sexually transmitted infections (STIs) is feasible, leads to improved sexual and reproductive health and contributes to preventing HIV transmission. The most advanced HIV epidemics have developed under conditions of poor STI control, particularly where ulcerative STIs were prevalent.

Thus, education-based prevention programs or “sex education” programs are among the strongest means of curtailing the spread of HIV/AIDS. It is widely accepted that young people have a right to sex education because it is a means by which they can protect themselves against unintended pregnancies and sexually transmitted diseases (STDs), including HIV infection. Sex education programs, implemented in diverse venues including schools or medical clinics, typically provide

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information to young people to help them form healthy attitudes and beliefs about sex, sexual identity, relationships, and intimacy. Sex education programs often also provide skills-based training to accompany knowledge so that young people can make informed decisions about their behavior, as well as feel capable of acting on and communicating those decisions to others. Sex education programs designed to reduce sexual and drug-associated HIV risk behaviors are, for all intents and purposes, today's "HIV vaccine," but there has been a great deal of debate on what constitutes appropriate content for sex education programs for young people.

This paper identifies effective components of sex education programs/interventions, and the effectiveness of, evidence-based HIV/AIDS prevention programs for diverse adolescent populations.

Keywords: *Sex education, HIV, AIDS, Counseling, STI*

To create and build a new solidarity in the face of all the standard, historical, expected, routine and powerful status quos which seek to divide us: to contribute to that societal transformation which offers hope against AIDS and for the world: this is a task — no, a destiny! Worthy of our past, our aspirations, our commitment, our dignity and our lives.

Sex is a natural process of life. However, many diseases are transmitted through building sexual relationship; the main is the HIV/AIDS. The most vulnerable groups are the teenagers' between 13 years of age to 17 years of age, who have the high chances of being infected. U.S. Department of Health and Human Service (2008) stated that "Compared with older adults, sexually active adolescents (10–19 years of age) and young adults (20–24 years of age) are at higher risk for acquiring STDs for a combination of behavioral, biological, and cultural reasons .

Adolescents are more likely to have multiple sexual partners and short-term relationships, to engage in unprotected intercourse, and to have partners who are themselves at high risk for STDs”.

It is estimated that 40 million people worldwide are infected with the Human Immunodeficiency Virus, most of whom will eventually contract the Acquired Immune Deficiency Syndrome, or AIDS. The global HIV/AIDS epidemic killed more than 3 million people in 2003, and infected an estimated 5 million. HIV/AIDS is the fourth biggest killer in the world (after heart disease, stroke and respiratory diseases).

As the HIV/AIDS epidemic remains on the top of the global health agenda of agencies such as the World Health Organization, Centers for Disease Control and Prevention and the United Nations, current initiatives to address HIV/AIDS (e.g. the Global Fund) primarily involve aid to provide expensive medications to HIV-infected people.

After the family home, schools are the primary places responsible for the development of young people. School health education can help teens adopt lifelong attitudes and behaviors that support overall health and well-being—including those that reduce their risk for HIV and other sexually transmitted diseases (STDs), and pregnancy.

AIDS is foremost a problem of the youth. Nearly 50% of the new HIV infections are occurring in young people between 15 to 24 years old. This is partly because a large part of the world is young (one fifth of the world population is between 10 to 19 years of age). Secondly, since AIDS HIV syndrome is essentially a sexually transmitted infection it affects the young sexually active people the most. The fundamental risk for young people is their ignorance about issues on sexuality, HIV/AIDS/STIs and the dangers of unprotected sex. Therefore, early intervention by targeting adolescents with information on HIV/AIDS/STIs as well

as skills to improve their self confidence and make them assertive may be an effective way to safeguard their future health status.

HIV/AIDS prevention education" means instruction on the nature of HIV/AIDS, methods of transmission, strategies to reduce the risk of human immunodeficiency virus (HIV) infection, and social and public health issues related to HIV/AIDS.

Nevertheless, to overcome from such devastating consequences of being infected, introduction of sexuality education has been implemented with anticipation of preventing the vulnerable teenagers from being infected from STD-HIV/AIDS and also to prevent others social members by sharing the general know-how knowledge.

To be more specific regarding the learning process of the subject regarding sexuality education in preventing STD-HIV/AIDS, it is found that the curriculum includes the method safe sexual relationship by using contraceptives.

In India, the recent decisions of several state governments to ban sex education in all schools concern everyone. According to this survey, only 80% of men and 57% of women have ever heard of AIDS. The reluctant attitude towards sex education in schools arises due to fear that sex education will increase the promiscuous behavior among the adolescents as they will be aware of various risk reduction procedures like condom use for safer sex. In most countries, the great majority of adolescents are poorly informed about sexuality and reproduction. Often policy makers, public opinion leaders, and parents believe that withholding information about sexuality and reproduction from young people will dissuade them from becoming sexually active.

The reluctant attitude towards sex education in schools arises due to fear that sex education will increase the promiscuous behavior among the adolescents as they will be aware of various risk reduction procedures like condom use for safer sex. In most

countries, the great majority of adolescents are poorly informed about sexuality and reproduction. Often policy makers, public opinion leaders, and parents believe that withholding information about sexuality and reproduction from young people will dissuade them from becoming sexually active. However, according to World Health Organization (WHO), these are misbeliefs if taken in a scientific way. In fact, good quality sex education does not lead to earlier or increased sexual activity among the adolescents. They need life skills in order to face the challenges of adulthood. During personal development, an adolescent's competence develops whenever there are opportunities to practice certain skills by understanding and using social conventions. Adolescents also prioritise livelihood skills and opportunities as very important to them. Due to access to sex education, adolescents will have not only scientific knowledge about it but also have healthy attitude toward this issue. According to the study by Easter Thamburaj *et al.*, in Chennai city, sex education will not prompt students to have sex. The study also shows that, majority of the students in public and private schools felt that sex education should be included in the curriculum. Such studies are important to find out the attitudes of students toward sex education.

India is one of the countries with large number of people affected with HIV/AIDS. Adolescent and young age groups are important risk groups concerned with HIV/AIDS and other STDs. According to NFHS 3, increasing HIV/AIDS education will be a critical step to curb the number of new HIV cases in India. Need of the hour is to promote healthy as well as risk free behavior among these high-risk groups as early as possible. Sex education is one of the important as well as an effective tool in prevention of HIV/AIDS and other STDs.

Quality sex education is a critical tool in securing lifelong sexual health, preventing HIV, other sexually transmitted

infections (STIs), and unintended pregnancies. People of all ages, and particularly our nation's young people, have the need for, and the right to, sexual health information to help secure their lifelong health and well-being.

However, according to World Health Organization (WHO), these are misbeliefs if taken in a scientific way. In fact, good quality sex education does not lead to earlier or increased sexual activity among the adolescents. They need life skills in order to face the challenges of adulthood. During personal development, an adolescent's competence develops whenever there are opportunities to practice certain skills by understanding and using social conventions. Adolescents also prioritise livelihood skills and opportunities as very important to them. Due to access to sex education, adolescents will have not only scientific knowledge about it but also have healthy attitude toward this issue. Further, only 68% of men and 35% of women know that consistent condom use can reduce the chances of getting HIV. These results underscore the pressing need to educate women and men about the virus, how it is transmitted, and how it can be prevented. According to NFHS 3, increasing HIV/AIDS education will be a critical step to curb the number of new HIV cases in India. Need of the hour is to promote healthy as well as risk free behavior among these high risk groups as early as possible. Sex education is one of the important as well as an effective tool in prevention of HIV/AIDS and other STDs.

Young people are among the most vulnerable to the HIV infection. They are highly impressionable and require appropriate information about reproductive issues including safe sexual behavior. It is essential for the teachers to create an environment where free and frank discussions between teachers, peer educators and students to take place. Integrating the issue of HIV/AIDS as a part of the larger issue of the family life education in the will go a

long way in bringing about change in the socially acceptable values.

Nevertheless, the understanding of need and importance of sexuality education has felt positive by the teenagers' students. This reflects the cognitive learning theory of reasoning themselves about its importance and rationality. However, the question still is yet to answer whether, the students have the tendencies to share the vision to the society by contributing their cognitive reasoning about being aware of preventing the disease by building sexual relationship. The cognitive process of learning, empower the teenagers' students about being aware of sexuality education and its important, however, the learning also indicates the process of attention, retention and motor reproduction.

Based on the theoretical construction, the societal benefits wouldn't be achieved if learning process of being attentive, retention and motor reproduction of such learning is not formulated on a continuous basis to change in behavior of practicing unsafe sexual relation.

Experience from around the world has shown that it is beneficial to educate the children about the process of growing up and its implications. This education on sexual and reproductive health will enable children in developing a stable value system and adopt a responsible lifestyle. Young people can also be agents of change and spearhead advocacy for HIV/AIDS education among peers, community members, parent's etc. information alone is not enough, rather it is the skill and empowerment to make correct choices that will prevent further spread of HIV/AIDS.

The biomedical information on the disease is not enough to convince people, including young people, to adopt a healthy behavior that prevents HIV/AIDS/STIs. What is needed is the motivation to act and skills to translate knowledge into practice. Through the achievement of a set of learning objectives, the paper

aims: to increase knowledge on adolescence, HIV/AIDS/STIs; to develop skills on self-assertiveness and to develop positive attitudes towards sexuality and those living with HIV/AIDS.

For teachers a program on HIV/AIDS is both challenging and rewarding. Most young people have never had the opportunity to openly talk about sex and drug use with adults. They welcome an open and honest discussion on it. They respect and probably will remember best-those teachers who care about the problems young people face in growing up.

In teaching about AIDS, it is really your relationship with your students that counts more than anything else. The success would depend upon how you impart knowledge to the students. It will help to equip the students to fight against AIDS temptation that open the way to pregnancy and STI's including HIV/AIDS.

Teachers play an important role in guiding the adolescents. Adolescents are ill equipped to deal with the impending changes in their body which makes them vulnerable to STDs, HIV/AIDS and premarital sex. This study attempts to study the impact of reproductive health education on the knowledge, attitude and practices of teachers, about which only a few studies are available. Senior Secondary schools of Amritsar and Department of Community Medicine, Government Medical College, Amritsar, Punjab, India. The study was started with 155 teachers (teaching class 9th -12th) who willingly participated from 50 senior secondary schools of Amritsar district. It was carried out in three phases. In first phase, after taking informed consent, the teachers filled a pretested questionnaire which was followed by an interactive session on reproductive health in second phase. In third phase, to study the impact of the interactive session and the sustainability of knowledge gained, they were again administered the same questionnaire after a period of 3 months. Maximum 74 (47.7%) teachers were aware of the psychosocial problems of adolescents. Majority 110 (71%) of the

teachers had only partial knowledge about pubertal changes. 117 (75.5%) teachers were unaware about genital hygiene. Only 33 (21.3%) teachers had adequate knowledge about different STDs. 91 (58.7%) and 54 (34.8%) of teachers had adequate knowledge about routes of transmission and prevention of AIDS respectively. Only 37 (23.9%) teachers were imparting sex education to students. After intervention significant favorable changes were seen in their knowledge, attitude and practices regarding most of above mentioned topics.

Sexuality education should be conducted in an atmosphere that promotes openness and acceptance. Most important factor for successful family life education is the attitude of the teacher. Unless the teacher can develop a positive, non judgemental attitude free from their own personal biases, education on this most important and yet sensitive area cannot succeed.

The sexuality education is concerned more with the development of skills for responsible behavior than with the knowledge of AIDS. Many students find it difficult to see how AIDS affect them. All too often they think of AIDS as “someone else’s problem, which cannot happen to them”. Understanding and learning is faster when students can relate to topics or when topics are of their interest.

Research shows that well-designed, well-implemented HIV/STD prevention programs can significantly reduce sexual risk behaviors among teens. A review of 48 comprehensive curriculum-based sex and STD/HIV education programs found that none of these programs increased the likelihood of teens having sex, while about two-thirds had a significant impact on reducing sexual risk behaviors among young people, including

- delay in first sexual intercourse
- decline in the number of sex partners
- increase in condom or contraceptive use

In the case of HIV, educated mothers are more likely to seek testing during pregnancy and to know that HIV can be transmitted by breastfeeding. They are also more likely to know that the mother-to-child transmission can be reduced by taking anti-retroviral drugs during pregnancy; only 27% of women with no education in Malawi were aware of this, compared with 60% of women with secondary education or higher.

Ensuring all children have access to school is essential, as young people who have stayed in school longer are more aware of HIV and AIDS. They are more inclined to take protective measures such as using condoms, getting tested and discussing AIDS with their partners. Schooling reduces the risk of HIV infection – but needs to play a bigger part in communicating knowledge about HIV and AIDS.

"Both comprehensive sex education and abstinence only programs delay the onset of sexual activity. However, only comprehensive sex education is effective in protecting adolescents from pregnancy and sexually transmitted illnesses at first intercourse and during later sexual activity. In contrast, scientifically sound studies of abstinence only programs show an unintended consequence of unprotected sex at first intercourse and during later sexual activity. In this way, abstinence only programs increase the risk of these adolescents for pregnancy and sexually transmitted illnesses, including HIV/AIDS," said psychologist Maureen Lyon, PhD, Chair of the committee that produced the report.

A comprehensive sexual health education shall be age appropriate; medically accurate and objective; available on an equal basis to English language learners; appropriate for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds; and appropriate for and accessible to pupils with disabilities. This education shall encourage students to communicate with their parents or guardians about human

sexuality and shall also teach respect for marriage and committed relationships.

Characteristics of Effective Sex Education

Experts have identified critical characteristics of highly effective sex education and HIV/STI prevention education programs. Such programs:

1. Offer age- and culturally appropriate sexual health information in a safe environment for participants;
2. Are developed in cooperation with members of the target community, especially young people;
3. Assist youth to clarify their individual, family, and community values;
4. Assist youth to develop skills in communication, refusal, and negotiation;
5. Provide medically accurate information about both abstinence and also contraception, including condoms;
6. Have clear goals for preventing HIV, other STIs, and/or teen pregnancy;
7. Focus on specific health behaviors related to the goals, with clear messages about these behaviors;
8. Address psychosocial risk and protective factors with activities to change each targeted risk and to promote each protective factor;
9. Respect community values and respond to community needs;
10. Rely on participatory teaching methods, implemented by trained educators and using all the activities as designed.

A person can take certain actions to reduce the risk of acquiring HIV. Education about these actions is an essential element of every successful prevention campaign. Everyone must be made aware of how to avoid acquiring HIV and must be

empowered to act on that information. The following concepts are widely.

- **ABC Prevention Elements**

Know Your Status: This element encourages individuals to seek voluntary counseling and testing services in order to access personal risk and determine their HIV status.

Abstinence: Refraining from sexual intercourse is the best way to prevent transmission of HIV and other STIs. Abstinence means not engaging in any sexual activity in which there is a direct or theoretical risk of exposure to blood, semen, or vaginal fluid.

Condoms: Correct and consistent use of latex condoms during sexual intercourse (vaginal, anal, and oral) can greatly reduce the chances of acquiring or transmitting HIV and other STIs. Natural-membrane condoms, often made from sheep gut, are not recommended, because they have tiny pores through which HIV can pass.

Microbicides: Microbicides are substances that are designed to block the transmission of or inactivate HIV when applied vaginally or rectally prior to intercourse. The advantage of such agents is that they are receptive partner controlled and could be used by both men and women. The ideal microbicide would

1. Come in many forms (e.g., cream, gel, suppository, films, lubricants),
2. Prevent other STI's,
3. Have both contraceptive and non contraceptive forms,
4. Be stable at tropical temperatures,
5. Be non teratogenic (not causing birth defects),
6. Be compatible with latex,
7. Be inexpensive,
8. Be easy to use, and
9. Be accessible to all.

APA has developed the following recommendations:

- Programs to prevent HIV and sexually transmitted diseases among youth should provide clear definitions of the behaviors targeted for change, address a range of sexual behaviors, be available to all adolescents (including youth of color, gay and lesbian adolescents, adolescents exploring same-sex relationships, drug users, adolescent offenders, school dropouts, runaways, mentally ill, homeless and migrant adolescents), and focus on maximizing a range of positive and lasting health outcomes.
- Only those programs whose efficacy and effectiveness have been well-established through sound scientific methods should be supported for widespread implementation.
- New programs to prevent HIV and sexually transmitted diseases among youth should be tested against those programs with proven effectiveness.

COUNSELLING IN HIV INFECTION

Counseling is a helping process aimed at problem-solving. It helps people to understand themselves better in terms of their own needs, strengths, limitations, and the resources they can avail of. It brings about change through a supportive relationship aiming to make the client independent through the interpersonal contact along with opportunity to ask questions and to meet frequently needed help greatly.

Tips for good counseling

- Greet your client
- Make him/her comfortable
- Create the confidence of the client in you and assure confidentiality.
- Listen carefully to his/her problems
- Do not interrupt while he/she is talking.
- Try to elicit more information regarding his/her problem.

- Counsel over a number of sessions and be sympathetic towards the client.
- Provide information on the issue for which your client has come.
- Help him/her to reach a decision.
- Time to time reassurance and follow regarding health condition.
- Encourage client to decide regarding communication of his problem to the family member/spouse.
- Willingness to listen, empathy, and understanding of client's dignity, good communication skills, non-judgmental attitude (i.e. should not bring his/her own values and impose on the client), maintenance of confidentiality, boosting their self confidence, improving family/community relationships, and support for the families of infected people by providing encouragement and care are some of the virtues to be developed.

Functions of counseling:

1. Prevention

Counseling is concerned with preventing infection with HIV and its transmission to either people and living with HIV/AIDS.

The main steps of preventive counseling are to:

- Determine whether individual/group has high risk behavior pattern.
- Help people understand and acknowledge their risk behavior patterns.
- Define with them how their life style and self image are linked to their behavior.
- Help individual define their potential for changing behavior.

- Work with individuals to introduce and sustain the modified behavior.

2. *Health Promotion*

This involves counseling those individuals having risk behavior patterns but not aware of the magnitude and the nature of risk involved to their life. It aims at creating this change focusing on behaviours that present a risk of HIV infection and reviewing ways of managing individual change.

3. *Specific protection*

Those infected with HIV should be give instruction as to ways by which they can prevent the spread of infection to others. An attitude of understanding should be adopted as the fact that he has tested positive is traumatic enough to accept. Since behavior change is going to be difficult, he should be asked to take certain precautions.

- Donot donate blood
- Use condoms while having sexual intercourse
- Do not share needles and syringes

Psychosocial Support

People diagnosed with HIV infection and HIV related illness and those close to them are confronted by a multitude of problems and often need emotional support and/or practical support. People have anxieties regarding hospitalization and depression because of stigma attached to their conditions. Counseling should help those infected by HIV to live full and productive lives by enabling them to take charge of their lives and help in decision making, thus, enabling people to remain active in their work and in their education. Families and friends can help to reduce their dependence on health and social services and reduce their psycho-social problems.

REQUIREMENTS OF COUNSELLING

Approaches to counseling will differ from individuals and groups depending upon the characteristics of the people being counseled and their social and family networks. Certain points which remain constant irrespective of the situation are:

- Rapport
- Acceptance
- Accessibility
- Consistency and accuracy
- Confidentiality

WHAT TO COUNSEL?

As HIV infection is progressive, it is necessary that counseling should be undertaken regularly to understand what the client is going through due to the various changes occurring within him and those around him. The counselor should also provide to the client necessary information regarding where he will be able to get medical support, community resources, and what changes he can make in his life styles to cope with emerging needs.

❖ Counseling before HIV Testing (Pre-test Counseling)

Counseling before the test should provide the individuals being tested with information on technical aspects of screening and possible personal, medical, social, psychological and least implications of being tested positive or negative. The information should be simple and up-to date. Testing should be organized in a way that minimizes the possibility of disclosure.

❖ Counselling after HIV Testing (Post- Test counseling)

If result is negative: the client may feel relief, however, caution should be exercised as following exposure to HIV there is a window during when negative result cannot be considered reliable. Further, a negative test should not give a false sense of security to a person indulging in unsafe sex. Three months must have elapsed

from possible exposure before a negative test can be considered to mean that there is no infection. A negative test result comes greatest certainty if six months have lapsed after last exposure. HIV infection can be prevented by avoiding high risk behavior, safe sex, avoiding sharing needles. In general, development of safer sex behavior has to be advocated to the client.

If result is positive: people diagnosed as having HIV infection should be told about their result privately and in confidence. Single test giving positive result does not necessary mean HIV infection. To establish HIV infection, three tests for antibodies based on different antigen methods are to test positive. Time should be allowed for the client to absorb the news. After a period of preliminary adjustment the client should be given clear and factual explanation or what the news means. This does not mean speculating about prognosis or estimate about the time left to live but for providing support and encouraging hope for achievable solutions to personal and practical problems that may result. The client must be informed where resources are available and possible treatment for some symptoms to HIV infections and efficacy or anti-viral treatment.

SUMMARY

India is one of the countries with large number of people affected with HIV/AIDS. Adolescent and young age groups are important risk groups concerned with HIV/AIDS and other STDs. According to NFHS 3, increasing HIV/AIDS education will be a critical step to curb the number of new HIV cases in India. Need of the hour is to promote healthy as well as risk free behavior among these high-risk groups as early as possible. Sex education is one of the important as well as an effective tool in prevention of HIV/AIDS and other STDs.

This Paper educates and informs on the prevention of sexual transmission of HIV, its counseling and common

psychological responses to a positive HIV test result. The precise risk of HIV transmission from one act of sexual intercourse is not known. The risk of becoming infected with HIV as a result of sexual intercourse depends on several factors, including the number of sexual partners a person has, the presence of other STIs, and the type of sexual contact involved. Refraining from sexual intercourse with an infected partner is the best way to prevent transmission of HIV and other STIs. Correct and consistent use of latex condoms during sexual intercourse (vaginal, anal, and oral) can greatly reduce the chances of acquiring or transmitting HIV and other STIs. Finally, there is the encouraging fact that HIV prevention programs can indeed work. At this point, prevention is the most realistic strategy for slowing the HIV pandemic. Major role of sex education in prevention of HIV/AIDS has been discussed widely. Thus it is vitally important to design, implement, analyze, and continually improve our prevention efforts.

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An Analysis of Gratitude and Hope In Relation To Happiness

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ABSTRACT

The present investigation studies the relationship between gratitude and hope and its contribution to happiness. Gratitude is a moral affect that contributes to an individual's positive emotion and well being. Hope is a positive expectation from the future that motivates goal directed behavior. Happiness is a positive trait influenced by one's cognition. The Adult Hope Scale (AHS) designed by C. R. Snyder, Gratitude Questionnaire (GQ-6) by Michael E. McCullough and the Subjective Happiness Scale (SHS) developed by Sonja Lyubomirsky were administered to 80 women students randomly selected. The results indicate that there is a positive correlation between gratitude and hope, gratitude and happiness, hope and happiness.

Keywords: *Hope, Gratitude, Happiness, Positive Psychology*

Happiness is the undying quest of life, the unquenchable thirst and the insatiable hunger of all human kind. Happiness is

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what we all seek for, what we long for. But can such bliss be nothing but an elusive state of mind, which is here one moment and gone the next, or is such a positive outlook attainable for a lifetime.

Happiness

Happiness is a positive emotional state that is subjectively defined by each person. The term is rarely used in scientific studies because there is little consensus on its meaning. Aristotle believed that *eudaimonia* (human flourishing associated with living a life of virtue), or happiness based on a lifelong pursuit of meaningful, developmental goals i.e “doing what is worth doing”, was the key to the good life. (Waterman 1993). Seligman divides happiness into three types: the pleasant life, the good life, and the meaningful life.

But the cognitive theorists view happiness as something you experience on the way to a goal, so happiness is goal-driven or goal motivated, while the hedonists see happiness as the end state or the goal itself. The motivation, according to hedonism, is simply the quest for pleasure and to avoid pain (Parducci, 1995).

Studies have shown that high concentrations of the neurotransmitter norepinephrine lead to feelings of elation and euphoria (extreme happiness) (Franken, 1994). Scientists have long known that there is a "pleasure center" or "reward center" in the brain.

Hope

Hope was considered one of the most fundamental of all the emotions (Averill et al, 1990). However, James Averill, a social constructivist, believes that hope does fit an emotional model. Averill bases his conclusion that hope is an emotion on the findings of a study that compared hope to two other emotions (love and anger). Averill and his colleagues found that subjects rated anger, love, and hope as all having the same five features: 1) all are difficult to control, 2) all affect the way you think or perceive events, 3) all affect the way you behave, 4) all motivate

behavior, increase persistence, enable one to go on (even in the face of adversity), and 5) all are common universal experiences. But the conclusions derived from this study can be questioned based on the fact that very few theorists consider love an emotion (at least not a prototypic emotion).

Hope usually involves some uncertainty of an outcome, typically concerns matters of importance, and usually reflects a person's moral values. Hope is frequently considered a temporary condition that is specific to a given situation and contingent upon one's skills or abilities. James Averill states that "hope is not associated with any specific physiological responses or reflex-like actions" (Averill et al, 1990).

Actually hope appears to be a primarily learned concept. In a series of studies done by Averill, et al (1990), he and his colleagues came to the conclusion that hope includes learned behaviors and thought processes that are acquired through the socialization process. Additionally there is a strong religious component to hope. Many Christian religions are built on hope and models of hope are implicitly taught in religious teachings.

Many studies have shown that cognitive strategies such as positive self-talk, reading uplifting books, envisioning hopeful images, listening to uplifting music, and lightheartedness (humor and laughter) are used by hopeful persons when suffering some "crisis" or adverse life event (Farran, 1995).

Hope also seems to be a powerful motivator (C.R. Snyder, 2010) a University of Kansas psychologist, posed the following hypothetical situation to college students: "Although you set your goal of getting a B in a class, after your first exam, which accounts for 30% of your grade, you find you only scored a D. It is now one week later. What do you do?" Snyder found that hope made all the difference. Students with high levels of hope said they would work harder and thought of a wider range of things they could do to improve their final grade. Students with moderate levels of hope thought of several ways to improve their

grade, but had far less determination to pursue them. Students with low levels of hope gave up attempting to improve their grade, completely demoralized (Goleman, 1995).

When Snyder compared the actual academic achievement of freshman students who scored high and low on hope, he found that hope was actually a better predictor of their first semester grades than were their SAT scores (which are highly correlated with IQ and therefore widely accepted as a predictor of how successful students will be in college) (Goleman, 1995).

Gratitude

There has been a lot of interest and study in the psychology of gratitude. Just think, that adopting the attitude and mindset of a grateful heart can actually add good years of health and prosperity to your life. That operates totally against the main stream of our society today. That is definitely swimming upstream and against the current of the way most people live.

Gratitude is derived from the Latin concept *gratia*, which entails some variant of grace, gratefulness, and graciousness. Gratitude emerges upon recognizing that one had obtained a positive outcome from another individual who behaved in a way that was a) costly to him or her b) valuable to the recipient c) intentionally rendered. As such, gratitude taps into the propensity to appreciate and savor everyday events and experiences. Gratitude is viewed as a prized human propensity in the Hindu, Muslim, Buddhist, Christian and Jewish traditions. On this point, Philosopher David Hume (1888, p. 466) went so far as to say that ingratitude is “the most horrible and unnatural of all crimes that humans are capable of committing”

Studies have shown,(Emmons & McCullough, 2003), that if you list and journal five things that you are grateful for, every single morning, before any negativism has a chance to creep into you, you will live longer and your life will be more fruitful by a whooping 25%. That’s one-quarter longer to live, just for feeling and expressing gratitude.

Need for the Study

In today's world, young people tend to be devoid of expressing their gratitude to their parents, elders, and teachers. They seem to live a life full of negative thoughts and feelings. They search happiness from external sources like social networking and other platforms of people. They easily lose hope in their near and far future because of life's failures like loss of love, unemployment, lack of tolerance, etc. They fall prey for suicidal thoughts, and fix on their destiny at a very early stage. Hence a small attempt to identify young people's level of hope and gratitude, in relation to happiness was intrigued at the moment.

Objective of the study:

1. The aim of the study was to assess the level of gratitude, hope and happiness of the female college students and
2. To investigate the relation between gratitude, hope and happiness of female college students.

REVIEW OF RELATED LITERATURE

Few previous research studies were discussed which sheds light on the variables relation of hope, gratitude and happiness.

Peterson (2007) studied on a sample of US adults ($N = 12,439$) completed online surveys in English measuring character strengths, orientations to happiness (engagement, pleasure, and meaning), and life satisfaction, and a sample of Swiss adults ($N = 445$) completed paper-and-pencil versions of the same surveys in German. In both samples, the character strengths most highly linked to life satisfaction included love, hope, curiosity, and zest. Gratitude was among the most robust predictors of life satisfaction in the US sample, whereas perseverance was among the most robust predictors in the Swiss sample. In both samples, the strengths of character most associated with life satisfaction were associated with orientations to pleasure, to engagement, and to meaning, implying that the

most fulfilling character strengths are those that make possible a full life.

Aga (2006) looked at the positive emotions of gratitude, pride, and happiness. Sixty-three Vanderbilt University undergraduate participants were randomly assigned to one of three conditions assessing their appraisals, motivations, and behaviors for one of the target emotions. Participants were asked to describe in detail a specific situation in which they experienced one of these emotions and then respond to a series of questions about their experience, as well as about their dispositional tendencies for these emotions. We discovered that gratitude was associated with higher usage of third-person pronouns, higher reports of other-responsibility, and higher associations with negative emotions. Pride was associated with higher reports of self-responsibility and higher levels of competitiveness. Happiness resulted in the highest ratings of positive affect. The results indicate that although happiness and pride appear to be purely positive emotions, gratitude has several associations with negative emotions, resulting in a new interpretation of its meaning.

Guse (2012) proposed that the gratitude is a psychological strength associated with enhanced positive psychological functioning. The relationship between gratitude and subjective well-being (SWB) has been confirmed in adults, but studies among adolescents and specifically South African adolescents, is scarce. The aim of this study was to investigate the prevalence of gratitude, and the relationship between gratitude and SWB among a group of adolescents from Gauteng (N=821) from four population groups (black, coloured, Indian and white). Participants completed measures assessing state gratitude (the Gratitude Adjective Checklist), trait gratitude (the Gratitude Questionnaire Six-item Form) and SWB (the Satisfaction with Life Scale, Multidimensional Student's Life Satisfaction scale, Affect meter Adolescents in this study experienced relatively high

levels of gratitude. Female participants reported a higher prevalence of both state gratitude and trait gratitude than male participants while Indian adolescents reported higher scores on state gratitude than white adolescents. Both trait and state gratitude were related to SWB, although the relationship between trait gratitude and SWB was stronger than the relationship between state gratitude and SWB. The findings support existing research on the relationship between gratitude and SWB.

Bono (2012) in a report on Science Daily, article titled “Growing Up Grateful Gives Teens Multiple Mental Health Benefits”, that increase in gratitude over a four-year period were significantly related to improvements in life satisfaction, happiness, positive attitudes and hope.”For the study, 700 students aged 10 to 14 answered questionnaires, then 4 years later, were surveyed again. Those categorized as “most grateful” were judged by the researchers as having 13 to 17% more purpose in life, more satisfaction with “life overall,” more happiness and hopefulness, less delinquency, and fewer negative attitudes. This New York based sample contained a mix of ethnic backgrounds, with 54% girls and (presumably) the rest boys. The lead researcher, made sweeping conclusions: “These findings suggest that gratitude may be strongly linked with life-skills such as cooperation, purpose, creativity and persistence and, as such, gratitude is vital resource that parents, teachers and others who work with young people should help youth build up as they grow up,”

Synder et.al (1991) reports that higher Hope scale scores were directly related to various indices of elevated happiness, satisfaction, positive emotions, getting along with others etc.

METHODOLOGY

The design for the present study was an ex-post facto method. A convenient sample of 80 women students of age ranging from 18 to 23 were selected from one of the Chennai City

Colleges. They were administered the scales for measuring gratitude, hope and happiness. The results were tabulated and interpreted by mean and correlational method.

Description of the Tools:

1. Gratitude Questionnaire - 6 (GQ-6) by Michael E. McCullough, Ph.D., Robert A. Emmons

The GQ-6 is a short, self-report measure of the disposition to experience gratitude. Participants answer 6 items on a 1 to 7 scale (1 = "strongly disagree", 7 = "strongly agree"). Two items are reverse-scored to inhibit response bias. The GQ-6 has good internal reliability, with alphas between .82 and .87.

2. Adult Hope Scale (AHS) by C. R. Snyder, University of Kansas

The adult hope scale (AHS) measures Snyder's cognitive model of hope which defines hope as "a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed energy), and (b) pathways (planning to meet goals)" (Snyder, Irving, & Anderson, 1991, p. 287). The adult hope scale contains 12 items. Four items measure pathways thinking, four items measure agency thinking, and four items are fillers. Participants respond to each item using a 8-point scale ranging from definitely false to definitely true and the scale takes only a few minutes to complete. The internal consistency (alpha level) typically has been in the .80 range, and test and retest reliabilities have been .80 or above over time periods of 8 to 10 weeks.

3. Subjective Happiness Scale (SHS) by Sonja Lyubomirsky, Ph.D.

The SHS is a 4-item scale of global subjective happiness. Two items ask respondents to characterize themselves using both absolute ratings and ratings relative to peers, whereas the other two items offer brief descriptions of happy and unhappy individuals and ask respondents the extent to which each

characterization describes them. The SHS has been validated in 14 studies with a total of 2,732 participants. Test-retest and self-peer correlations have suggested good to excellent reliability, and construct validation studies of convergent and discriminate validity have confirmed the use of this scale to measure the construct of subjective happiness.

RESULTS AND DISCUSSION:

Table 1 shows the mean values of the sample for Gratitude, Hope and Happiness

Data Analysis Method	Gratitude	Agency Hope	Pathways Hope	Hope Total	Happiness
Mean	32.34	24.41	25.28	49.71	20.24
Interpretation	High	High	High	High	High

From the above table it is seen that the mean of gratitude scores of the sample is 32.34, which is interpreted as high. The sample also shows a high level of gratitude which actually reflects their level of happiness. It is also clear from the table that the mean value of the sample for hope is high. The components of hope, which is the agency hope score and the pathways score for hope are high and the total score for hope is also high. It is found that people who are scored high in their hope level also scored high in the level of happiness. The mean value of the sample for happiness also found to be high, which clearly depicts the direct link between gratitude and hope towards happiness.

Correlation Coefficient of Gratitude, Hope and Happiness:

Table 2 Indicates the Correlation coefficient values between Happiness and Gratitude

Variable (X)	r value	Correlation
Gratitude	r=0.1307	Positive

An Analysis of Gratitude and Hope In Relation To Happiness

Happiness was correlated with Gratitude, Agency Hope and Pathways Hope and the Total Hope scores of the sample were found to be statistically significant and have a positive correlation with each other. The higher the level of gratitude, the greater is the happiness level. That is if a person has scored high in the level of gratitude, then the person is also scored a high level in the happiness scale. Hence there is a positive relationship between happiness and gratitude. Though the correlation is very low, it shows a positive relation between the gratitude, hope and happiness.

Table 3 indicates the correlation coefficient values between and Hope and Happiness

Variable	r value	Correlation
Agency hope	r= 0.3021	Positive
Pathways Hope Score	r= 0.1537	Positive
Hope Total	r=0.271	Positive

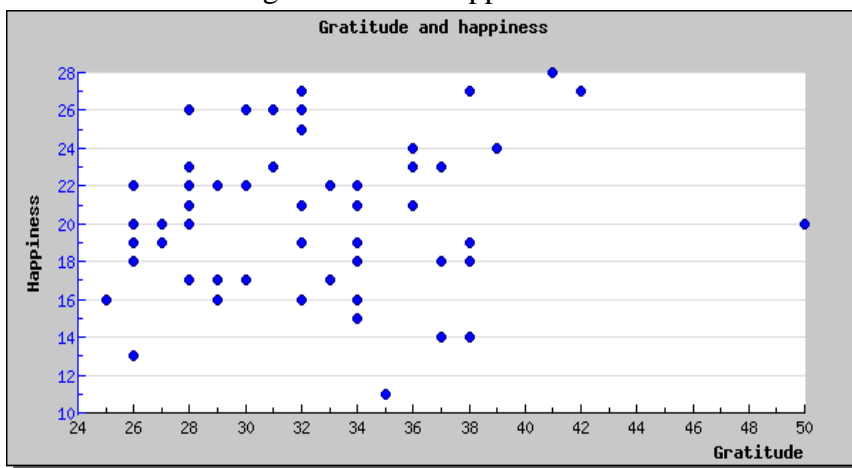
The table indicates the correlation coefficient values of happiness and hope and its sub components agency hope and pathways hope. Agency Hope is high, Happiness is high. Similarly, pathway hope is high; happiness is higher in their value. The overall score of hope of the selected sample is high and has a positive correlation with happiness.

Table 4 indicates the correlation coefficient values between and Hope and Happiness

Hope (x)	r value	Correlation
Gratitude(y)	r=0.0943	Positive

Chart I:

The scatter gram is plotted below which shows the positive correlation between gratitude and happiness.

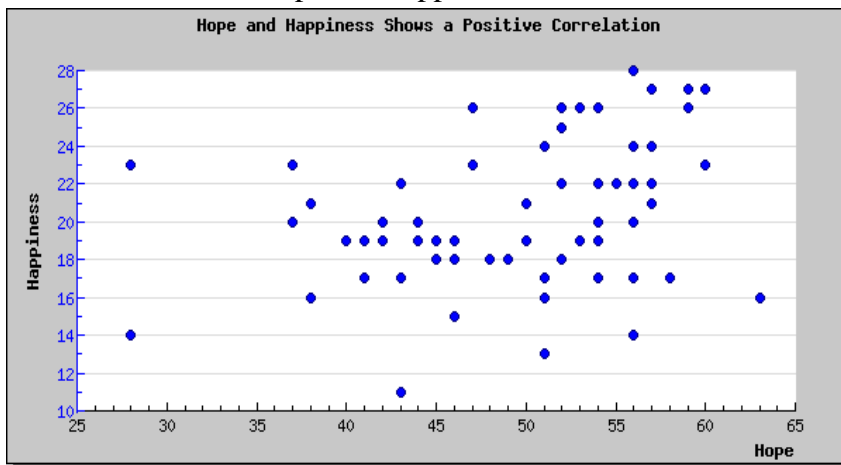


Interpretation:

The level of gratitude was high and the level of happiness is also found to be high for the sample.

Chart II:

The scatter gram is plotted below which shows the positive correlation between hope and happiness.

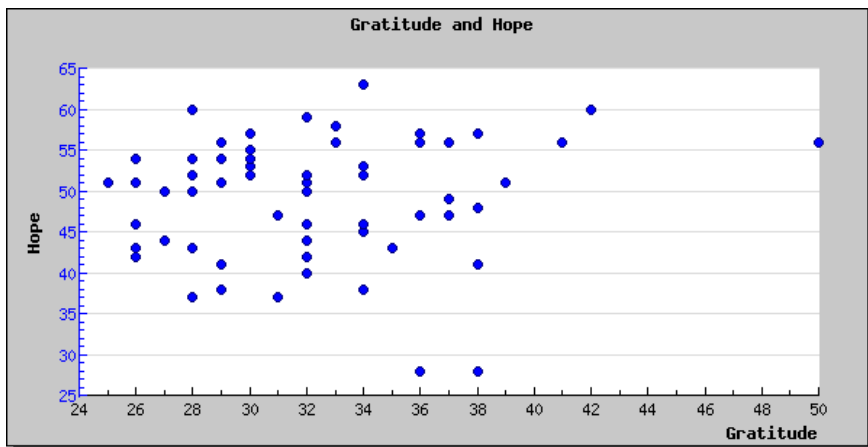


Interpretation:

The level of hope was high and the level of happiness was also found to be high for the sample.

Chart III:

The scatter gram is plotted below which shows the positive correlation between gratitude and hope.



Interpretation:

The hope level and gratitude also shows a positive correlation with each other.

Hence practicing gratitude is a good sense of understanding because eventually it increases the level of happiness. The study also evidences of gratitude and hope directly related to happiness.

There is proven scientific evidence now, that verifies this, and we would definitely encourage instituting this into our everyday life. It's good for us and we will live longer. People who were in the gratitude condition felt fully 25% happier - they were more optimistic about the future, they felt better about their lives and they even did almost 1.5 hours more exercise a week than those in the hassles or events condition.

CONCLUSION

1. The study investigated the level of gratitude, hope and happiness and found that to be high for the sample of college students.
2. There exists a significant positive relation existing between gratitude and happiness, hope and happiness and hope and gratitude.

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Impact of Family Dysfunctions on Child and Adolescents Mental Health

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ABSTRACT

None of us live alone. Family is the primary unit where individuals find their self identity and desire to live. A rigid definition of family involves persons united by ties of marriage, blood, or adoption. The members of a family have a common habitat, share same roof and constitute a single house hold. They interact and communicate with each other in the performance of roles, as spouse, mother and father, son, daughter, etc. This unit has certain common characteristics in all societies although the relationship between the individuals, family, society, culture and civilization are variable and complex. The family provides for the child's biological needs and simultaneously directs its development towards becoming an integrated person capable of living in society and maintaining and transmitting culture. Specific to mental health, family plays a very significant role in development of positive mental health and making a person psychologically resourceful and socially organized.

Keywords: Family, Child, Adolescents, Mental Health

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None of us live alone. Family is the primary unit where individuals find their self identity and desire to live. A rigid definition of family involves persons united by ties of marriage, blood, or adoption. The members of a family have a common habitat, share same roof and constitute a single house hold. They interact and communicate with each other in the performance of roles, as spouse, mother and father, son, daughter, etc. This unit has certain common characteristics in all societies although the relationship between the individuals, family, society, culture and civilization are variable and complex. The family provides for the child's biological needs and simultaneously directs its development towards becoming an integrated person capable of living in society and maintaining and transmitting culture. Specific to mental health, family plays a very significant role in development of positive mental health and making a person psychologically resourceful and socially organized (David, 1978).

What is a dysfunctional family?

A dysfunctional family is a family, in which conflict, misbehavior and even abuse on the part of individual members of the family occur continually, leading other members to accommodate such actions. Children sometimes grow up in such families with the understanding that such an arrangement is normal. Dysfunctional families are most often a result of the alcoholism, substance abuse, or other addictions of parents, parents' untreated mental illnesses/defects or personality disorders, or the parents emulating their own dysfunctional parents and dysfunctional family experiences. Violence and verbal abuse are typical outcomes. Dysfunctional family members have common symptoms and behavior patterns as a result of their common experiences within the family structure. This tends to reinforce the dysfunctional behavior, either through enabling or perpetuation. The family unit can be affected by a variety of

factors. Family dysfunction can be any condition that interferes with healthy family functioning. Most families have some periods of time where functioning is impaired by stressful circumstances (death in the family, a parent's serious illness, etc.). Healthy families tend to return to normal functioning after the crisis passes. In dysfunctional families, however, problems tend to be chronic and children do not consistently get their needs met. Negative patterns of parental behavior tend to be dominant in their children's lives.

Sexual abuse happens to both boys and girls. It is committed by both men and women. In most cases, sexual abuse is part of an overall family pattern of dysfunction, disorganization, and inappropriate role boundaries. Responsibility for sexual abuse in all cases rests entirely with the adult. No child is responsible for being abused. Most sexually abused children are too frightened of the consequences for themselves and their families to risk telling another adult what is happening. As a result they grow into adulthood carrying feelings of self-loathing, shame, and worthlessness. They tend to be self-punishing and have considerable difficulties with relationships and with sexuality. Regardless of the kind of dysfunction or abuse, effects vary widely across individuals. Support from other healthy adults, success in other areas, or positive changes in the family can help prevent or minimize negative effects. The following questions may help you identify how you may have been or continue to be affected (Beavers, 1982; Ackerman, 1993).

Types of dysfunctional families:

1) According to Janet Kizzia identified four types of "troubled or dysfunctional family systems," in the context of describing the cardinal features of alcoholic families, such as:

- The Alcoholic or Chemically Dependent Family
- The Emotionally or Psychologically Disturbed Family
- The Physically or Sexually Abusing Family

- The Religious Fundamentalist or Rigidly Dogmatic Family

2) Kizziar (1989) mentioned that in all those families substance addiction or alcoholism tends to become more problematic as other non-dependent members of the family somehow promote or fuel the evil habit by becoming reluctant to them, or quietly accepting their addictive behaviour.

3) Steven Farmer (1989) identified following symptoms in dysfunctional families:

- Inconsistency and Unpredictability
- Role reversals ("parentifying" children)
- Closed family system" (a socially isolated family that discourages relationships with outsiders)
- Denial (i.e. a refusal to acknowledge the alcoholism of a family member; ignoring complaints of physical, emotional and sexual abuse)
- Lack of empathy toward family members
- Lack of clear boundaries (i.e. throwing away personal possessions that belong to others, inappropriate touching, etc.)
- Mixed Messages
- Extremes in conflict (either too much or too little fighting between family members)

4) Neurath (2002) also categorized dysfunctional family by identifying faulty parenting as:

- Dogmatic or chaotic parenting" (applying harsh and inflexible disciplines on children)
- Showing condition-based love and affection to children
- Socially isolated parents or parents with low social mixing skills
- Children are not expected to question parents or children not allowed to dissent or argument with parents

- Children are not allowed to develop their own value system by parents
- Parents are disrespectful to children's need, prestige and existence
- Signs of emotional intolerance from parents i.e., family members not allowed to express the "wrong" emotions

Examples of Faulty Parenting in Dysfunctional Families:

a) Deficient Parents:

Deficient parenting is characterized by having marked inadequacies in parents to provide children emotional and material care. These parents would likely to hurt their children more by omission than by commission. Frequently, chronic mental illness or a disabling physical illness contributes to parental inadequacy. Children tend to take on adult responsibilities from a young age in these families. Parental emotional needs tend to take precedence, and children are often asked to be their parents' caretakers. Children are robbed of their own childhood, and they learn to ignore their own needs and feelings. Because these children are simply unable to play an adult role and take care of their parents, they often feel inadequate and guilty. These feelings continue into adulthood.

b) Controlling Parents:

Unlike the deficient parents, controlling parents fail to allow their children to assume responsibilities appropriate for their age. These parents generally show excessive dominating attitude to children and making decisions for their children well beyond the age at which this is necessary. Controlling parents are often driven by a fear of becoming unnecessary to their children. This fear leaves them feeling betrayed and abandoned when their children become independent. On the other hand, these children frequently feel resentful, inadequate, and powerless. Transitions into adult roles are quite difficult, as these adults frequently have

difficulties making decisions independent from their parents. When they act independently these adults feel very guilty, as if growing up were a serious act of disloyalty.

c) Alcoholic Parents:

Alcoholic families tend to be chaotic and unpredictable. Rules those are applicable to one day may not be applicable in other days. Promises are neither kept nor remembered. Expectations vary from one day to the next. Parents may be strict at times and indifferent at others. In addition, emotional expression is frequently forbidden and discussion about the alcohol use or related family problems is usually nonexistent. Family members are usually expected to keep problems a secret, thus preventing anyone from seeking help. All of these factors leave children feeling insecure, frustrated, and angry. Children often feel there must be something wrong with them which make their parents behave this way. Mistrust of others, difficulty with emotional expression, and difficulties with intimate relationships carry over into adulthood. Children of alcoholics are at much higher risk for developing alcoholism than are children of non-alcoholics.

d) Abusive Parents:

Abuse can be verbal, physical, or sexual.

1 Verbal abuse - such as frequent criticism, being critical to children's behaviour, frequently putting down children in front of others, comparing with other children regarding their academic, scholastic, behavioural, even physical appearances and showing less positive reinforcements - can have enduring effects, particularly when it comes from those entrusted with the child's care. Some verbal abusers are very direct, while others use subtle put-downs disguised as humor. Both types are equally damaging to children.

2 Definitions of physical abuse vary widely. Many parents, at one time or another, have felt the urge to strike their child. With physically abusive parents, however, the urge is frequent and little

effort is made to control this impulse. The Federal Child Abuse Prevention and Treatment Act (U.S. Department of Health and Human Services, Administration for Children and Families) defines physical abuse as *"the infliction of physical injuries such as bruises, burns, welts, cuts, bone or skull fractures; these are caused by kicking, punching, biting, beating, knifing, strapping, paddling, etc."* Physically abusive parents can create an environment of terror for the child, particularly since violence is often random and unpredictable. Abused children often feel anger. Children of abusive parents have tremendous difficulties developing feelings of trust and safety even in their adult lives. While parents may justify or rationalize verbal or physical abuse as discipline aimed at somehow helping the child, there is no rationalization for sexual abuse.

3. Sexual abuse is the most blatant example of an adult abusing a child purely for that adult's own gratification. Sexual abuse can be any physical contact between an adult and child where that contact must be kept secret. Demonstrations of affection -- such as hugging, kissing, or stroking a child's hair -- that can be done openly are quite acceptable and even beneficial. When physical contact is shrouded in secrecy then it is most likely inappropriate. Sexual abuse happens to both boys and girls. It is perpetrated by both men and women. It cuts across lines of race, socioeconomic level, education level, and religious affiliation. In most cases, sexual abuse is part of an overall family pattern of dysfunction, disorganization, and inappropriate role boundaries. Responsibility for sexual abuse in all cases rests entirely with the adult. No child is responsible for being abused. Most sexually abused children are too frightened of the consequences for themselves and their families to risk telling another adult what is happening. As a result they grow into adulthood carrying feelings of self-loathing, shame, and worthlessness. They tend to be self-punishing and have considerable difficulties with relationships and with sexuality.

Effects of faulty parenting on children:

Children growing up in a dysfunctional family may have to adopt following six basic roles, which are not healthy:

- a) The Good Child – a child who takes over the parental role.
- b) The Problem Child – the child who has been held responsible for most problems in his family, although he is found to be the most emotionally stable one in the family.
- c) The Caretaker Child– the child who takes the maximum responsibility for the emotional well-being of the family.
- d) The Lost Child – the inconspicuous, quiet one, whose needs are often ignored or hidden by family members.
- e) The Mascot Child– the child who frequently uses humours or adopts the role of a comedian to divert attention away from the increasingly dysfunctional family system.
- f) The Mastermind Child– the child who has opportunistic attitudes and who capitalizes on the other family members' faults in order to get whatever he/she wants.

Children of dysfunctional family system might as well develop following enduring problems in their later life:

- a) Being distrustful to others or being suspicious to others' actions
- b) Problem in either expressing or recognizing emotions or emotional needs of others
- c) Low self-esteem and poor self-image
- d) Less skillful in forming and maintaining healthy relationships with others

Parental & Familial factors

1. **Attachment /bonding:** - Mary Ainsworth et al (1978) first described patterns of mother infant interaction following brief episode of experimentally contrived separation denoted as 'strange situation'.

Three types of attachment were:

- Secure attachment
- Anxious attachment
- Resistant attachment

Lack of secure attachment predicts future psychological problem (Fonagy et al. 1994).

2. **Parental separation& loss:** Psychiatric morbidity has been found to be persistently higher in bereaved children than controls, at both short term & long term follow-up Depression & anxiety disorders occur most commonly but alcohol & drug use in males is particularly high (Kranzler et al, 1990). However, bereaved children may show resilience in presence of various protective factors. Risk factors in children are:-

- Young age (esp before 11 yrs)
- Female Sex
- No preparation for death
- Sudden or catastrophic death
- Witnessing the death
- Death of mother
- Prior ambivalent relationship
- Previous psychiatric disorder
- Previous & subsequent losses
- Poor social support
- Inability to mourn, no involvement in death rituals
- Lack of bereavement counseling.

3. **Parental Psychiatric/Medical Illness:** Besides contributing to genetic transmission, parental illness also adversely affects children via environmental mechanisms like insecure attachment, chaotic family environment, marital disharmony & economic difficulties.

- Parental depression is associated with 3 fold increased risk of depression in offspring, as well as increased rates of phobias/panic disorder/ alcohol dependence & conduct disorder (Weissman et al, 1997).

- Parental substance use & personality disorders contribute to conduct disorders & substance abuse (Merikangas et al, 1998).
- Parental chronic physical illness like cancer/ AIDS/heart disease cause increased risk for anxiety/ low self esteem & poor social skills (Grant and Compas,1995)
- 4. **Parenting style:** 4 Types of parenting styles have been described with different developmental outcomes of the child ;-
 - Authoritative style: is a protective factor with maximum benefit to child (Darling & Steinberg, 1993).
 - Authoritarian style: results in shy/anxious child.
 - Permissive style: results in poor impulse control
 - Neglecting style: results in conduct problem.
- 5. **Parental marital status/relationship:**
 - Parental divorce is associated with psychological/behavioral problems, specially in short term with boys, with particular risk for conduct problems & academic failure (Cherlin et al, 1991)
 - More than the divorce itself, marital discord/ conflict preceding divorce especially increase risk of conduct problems. Single parent & step-parent / reconstituted families show higher mean levels of emotional problems & educational underachievement (Dunn et al, 1998).
- 6. **Dysfunctional/disorganized family environment:** Apart from above family related factors, increased risk for both externalizing/internalizing disorders in children are associated with :
 - Inconsistent/unclear rules.
 - Ineffective monitoring & supervision,
 - Lack of intellectual stimulation.
 - Overpunitive/harsh discipline
 - Excessive use of corporal punishment
 - Younger maternal ages (especially teenage mothers)

- Large family size.
- Abnormal parent child interactions like hostility /lacking of warmth/disengagement/overprotection/inadvertent reinforcement of undesirable behaviors.

7. Child abuse and maltreatment:

- Child abuse includes physical abuse/sexual abuse/emotional abuse & neglect.
- Physical abuse (non-accidental physical injury) results in ‘battered child syndrome’ & results in physical sequelae as well as behavioral problems like poor social skills, chronic oppositional & aggressive behavior & academic failure (Cicchetti & Toth, 1995).
- Sexual abuse : This can lead to wide range of psychological sequelae : - (Kendall-Tackett et al, 1993)
 - Affective symptoms : phobia/PTSD/Depression.
 - Behavior problems: conduct disorder, hyperactivity, sexualized behaviour, self-destructiveness.
 - Cognitive functioning: Educational/language difficulties.

However, ultimate risk is tempered by effects of both quality of family environment & nature of subsequent life events.

- Neglect: (Physical, emotional, medical care & educational) results in failure to thrive (Psychosocial dwarfism), developmental delays, attachment disorders & conduct problems.

II. Peer related factors: Beyond family, relationships with peers provide unique & essential contribution to social, emotional & cognitive development. Increased risk may be caused by (Hawkins, 1992):

- a. Rejection /isolation by peers: results in low self esteem & poor social skills.
- b. Affiliation with behaviorally deviant peers: predispose to conduct problems.

III. School related factors: School life brings its own particular demands & challenges. Adverse influences include (Rutter, 1985):

- a) Frequent change of school
- b) Chaotic school environment
- c) Absence of consistent discipline/rules
- d) Corporal punishment
- e) Bullying in school

IV. Community related factors:

- a) Poverty & social disadvantage: Lower socioeconomic class & persistent financial difficulties are strongly associated with difficulties in cognitive skills & educational achievements (Carr, 1999).
- b) Urban inner city residential areas; Risk of disorders were doubled in some studies (Rutter et al, 1975).
- c) Increased community violence, criminality and unemployment
- d) Lack of supportive community & social network
- e) Increased prevalence of alcohol & substance use.

Protective Factors:

1. Biological factors: (Rutter, 1991)

- Good physical health
- Absence of genetic vulnerabilities
- No history of serious illness or injuries
- Uncomplicated birth
- Adequate nutrition
- Female gender before puberty & male gender thereafter

2. Psychological factors (Carr, 1999)

- Easy temperament
- High level of intellectual ability
- High self esteem
- Use of mature defenses & functional coping

3. Familial factors (Darling & Steinberg, 1993)

- Secure attachment
- Authoritative parenting style
- Parental marital harmony
- Involvement of father in child –rearing
- Explicit/consistent family rules
- Clear & direct communication

4. Educational Factors (Rutter, 1985)

- High quality day-care
- Preschool early intervention educational programme
- Favorable school environment with firm authoritative leadership
- Involvement with peer group

Emergent Role of Families in Mental Disorder

Available evidence suggests that the prevalence of psychopathology among children in the family or foster care is higher than would be expected from normative data³. Family is the main socializing agent for the child and is important in all aspects of a human development. From family, an individual gets emotional, financial, mental support and is able to cope with his/her problems with the help of the members of the family. Scientific observations on mental disorders and mental patients have indicated that family contributes significantly to the development of mental disorders. The importance of the role of the family as a causative factor in the development of mental disorders is getting more and more established, particularly over the past decade. Clinical work and research on families, theories of family structure and dynamics had their beginning since 1940s with the work by Social scientist (Meyer and Sullivan). It is indicated that family has a crucial role in the development of mental disorders. Mental disorders develop as a result of family pathology or faulty communication or interpersonal relationship.

Although the individual is affected, yet the whole family is sick because of inter or intrapsychic problems⁴. The role of family in mental disorder/psychopathology has been classified into three broad categories such as:-

1. Causative role of the family
2. Maintenance role of the family and
3. Therapeutic role of the family.

Therapeutic Role of the Family

It is universally recognized that family plays a crucial role in the raising of children to become reasonably well adjusted member of the society. The positive role of the family's mental health care programmes has been recognized relatively recently.²⁹ Substantial evidence demonstrates the benefit of involving families in the treatment and management of schizophrenia, mental retardation, alcohol dependence and childhood behavior disorder. These are indications that the outcomes for patients living with their families are better than for those in institutions. It has been seen that by changing the emotional atmosphere in the home, the relapse can be reduced.³⁰ In contact to epilepsy related factors, family factors especially those related to quality of the parent child relationship appeared to be strong predictors of psychopathology. In treating children with epilepsy, clinician should be aware of the importance of the parent-child relationship quality. Strengthening the relationship quality may prevent or reduce psychopathology.³¹ The family commonly provides useful information about the patients and other illness. This facilitates a treatment plan, in which the family can play a prominent role in helping to supervise medication, encouraging participation in rehabilitation programmes generally providing an environment conducive to promoting recovery or reducing disability. The family support provides an opportunity to patient to ventilate their anxiety freely, to arise at a shared understanding of the disease and to explore various alternative

coping strategies.³² Family can offer an important reinforcement in the psychiatric therapeutic management. There are some basic steps in the family treatment to include family to participate in the management.

These are –

- *Improving problem solving ability of the families*
- *Educating the family regarding the illness.*
- *Modification of the family communication patterns*
- *Family guidance.*
- *Lowering the expressed emotion of the family members towards the patients.*
- *Manipulation of the power alliance within the family.*
- *Expanding social network.*
- *Enhancing social support.*
- *Crisis intervention.*

The therapy for marital discord is the core approach to family change.¹⁶ Several family intervention approaches for schizophrenia have been developed based on the general assumption that maladaptive interaction pattern within the family produce high level of stress for the patient and tend to relapse.³³ These intervention have attempted to reduce the risk of relapse either by altering communication and problem solving in the home or by the modifying family attitudes about the patient through education about the illness. Home visit and focused communication training has been shown to be effective in studies.³³ Reduction of expressed emotion is associated with good treatment outcome, especially in the families with high level of face to face contact with the patient. Superior patient outcome with two variations of behavioral approach compare to family education and routine treatment.³⁴ Intensive behavioral intervention may not be cost effective and that change in the family communication pattern may only be important for a subset of families.

CONCLUSION

The family unit is the single most important variable in the onset, progression, treatment and outcome of psychiatric illness or mental disorders. Various researchers as well as theoretical formulations have been explored to understand the role of family pathology in the causation (genesis) and maintenance of mental disorders. However, most of the families studied have been carried out in relation with schizophrenia and some with affective disorders, particularly depression. Some of the clinical studies clearly mentioned, especially in early childhood experiences, familial stress factors such as parental death, parental separation, parental rejection, marital discord, violence at home, faulty family communication, etc. which have lifelong effects on mental health. However, the etiological aspects of various mental disorders require more exploration in the context of family life and its dynamics. Falling sick is a family event. It affects the well being of not only the patient but also that of the whole family by disrupting the normal day to day routine. The family is required to mobilize its internal and external resources to cope with the impending crisis. For any meaningful intervention, it is important to identify families, which are more vulnerable and need support. The family as a unit is still the best bet for health care intervention. Situation can improve by helping the patient and family members to develop realistic expectation about the problem and its ramification.

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The theme “Mental Health: Journey from Illness to wellness” is self explanatory and is the bloodline of all that we do. With changing times, the perception of psychologists has shifted towards a solution oriented positive approach against the earlier problem focused approach. This led us to relook at research and one issue that we felt that needed to be looked at is the kind of research that is being undertaken currently. Research should lead to insights that bring about beneficial change in people and society. Research should feed into various streams of society leading to necessary changes that bring about understanding about issues and problems and what action can be taken to resolve those problems.

There has been a considerable body of research into the effectiveness of interventions to promote/protect the mental health and wellbeing. This special review is going to be the deciding parameter on which henceforth we will publish theme based special review journals. We know you will continue to support us in this endeavor so that whatever we do adds meaning and value to the world of knowledge and to the psychological society and mental health professionals.



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